GROUP AGREEMENT

kp.org

Multnomah County Employees

KAISER PERMANENTE®

All Plans offered and underwritten by
Kaiser Foundation Health Plan of the Northwest

Thursday, January 5, 2023

Tami Mahrt
Multnomah County Employees
Employee Benefits
501 SE Hawthorne Blvd Ste 400
Portland, OR 97214

Group number: 1569-499

Dear Tami,

Thank you for selecting Kaiser Permanente for your group's health care needs.

Enclosed is the Senior Advantage with Part D Plan *Group Agreement* effective 1/1/2023 through 12/31/2023 for Multnomah County Employees. The *Group Agreement* includes group contract provisions, such as monthly Premium amounts, and incorporates the *Evidence of Coverage* (*EOC*), which is the member portion of the contract. The *EOC* explains benefits and cost share amounts, limitations, exclusions, and other information to help the member understand their plan.

Also enclosed is a *Summary of Changes and Clarifications*. Please review this to learn about changes to the *Group Agreement* for this year.

We know you have a choice of health plans, and we appreciate your business. If you have any questions about this *Group Agreement* or your health plan, please contact Lilian Belaen at (971) 284-0844.

Sincerely,

Kaiser Permanente Sales & Account Management Team
Enclosures

/rw

Kaiser Permanente Building
500 N.E. Multnomah Street, Suite 100
Portland, OR 97232-2099

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KAISER PERMANENTE

2023 *Group Agreement* and *Evidence of Coverage* Summary of Changes and Clarifications for Oregon Large Employer Groups

This is a summary of changes and clarifications that we made to your *Group Agreement* for the 2023 plan year. The *Group Agreement* includes the *Evidence of Coverage* (*EOC*), *Benefit Summary*, and any applicable notices, riders and endorsement documents. This summary does not include minor changes and clarifications we are making to improve the readability and accuracy of the *Group Agreement*, or changes that may occur throughout the remainder of the plan year as a result of federal or state mandates.

Other plan-specific or product-specific benefit changes, including changes to deductible, copayment or coinsurance amounts, may apply to your plan. Please refer to the 2023 renewal proposal and/or confirmation for your group and the 2023 Oregon and Washington Plan Changes brochure for information about these types of changes.

This Summary of Changes and Clarifications supplements the information contained in your *Group Agreement*. In the event of conflict between this summary and the *Group Agreement*, the *Group Agreement* shall control. Unless another date is listed, the changes described in this summary are effective when your *Group Agreement* renews in 2023. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

Changes and clarifications that apply to medical plans

These changes apply to Kaiser Permanente's commercial (non-Medicare) group plans. Changes to our Senior Advantage plans may be found at the end of this summary.

Benefit changes

- **Colorectal cancer screening.** In the "Preventive Care Services" section of the *EOC*, we updated the intervals for colorectal cancer screenings and expanded the coverage description, in accordance with USPSTF guidelines and CMS FAQ 51 regarding coverage for preventive colonoscopies. Colorectal cancer screenings covered as preventive services include: fecal occult blood test, colonoscopy, follow-up colonoscopy after abnormal findings identified by flexible sigmoidoscopy or CT colonography screening, bowel prep medications and anesthesia for the screening procedures, polyp removal performed during a screening procedure, and pathology on a polyp biopsy.
- **Dependent out-of-area coverage.** For traditional, deductible and high deductible plans, we added naturopathic medicine visits to the services that we cover under the limited "Out-of-Area Coverage for Dependents" benefit.
- **Insulin cost share cap.** We lowered the Member cost share cap shown in the *Benefit Summary* from $75 to $35 for each 30-day supply of insulin.
- **Kaiser Permanente at Home™.** We added coverage under certain medical plans that provides care in a Member's home as an alternative to receiving acute care in a hospital. Services include home visits by healthcare professionals, communication devices, and medically necessary supplies and equipment. This coverage is not available in high deductible plans.

Benefit clarifications

- **Breastfeeding equipment and supplies.** We clarified in the "Maternity and Newborn Care" section of the *EOC* that breastfeeding equipment and supplies are covered under the Preventive Care Services benefit.
- **Childbirth Services.** We corrected an error in the "Women's Health Care Services" section of the Added Choice® *EOC* by removing a sentence that referred to home childbirth services. For Added Choice®, PPO Plus®, and Dual Choice PPO® plans, we also added explicit exclusion language to the "Maternity and Newborn Care" section, clarifying that we do not cover birthing center services or home birth services.
- **Court-Ordered screening interviews or treatment programs.** We clarified the "Substance Use Disorder Services" section of the *EOC*, adding court-ordered screening interviews or treatment programs for a Member convicted of driving under the influence of intoxicants (DUII) to the list of covered outpatient Services.
- **Federal No Surprises Act/Balance Billing Protection.** Several updates were made to the *EOC* to meet the requirements of the federal No Surprises Act and applicable state law. This includes added or revised definitions for "Ancillary Service," "Charges," "Emergency Services," and "Independent Freestanding Emergency Department," as well as modifications in the "Emergency Services," "Post-Stabilization Care," and "External Review" sections.
- **Infertility diagnosis services.** We removed an exclusion for donor semen, donor eggs, and the procurement and storage from the "Infertility Diagnosis Services" section because these services are associated with treatment of infertility, and are addressed in the "Infertility Treatment Services Rider." Also in this section, we added intrauterine insemination (IUI) to the example list of procedures for conception by artificial means that we do not cover unless the Group has purchased an "Infertility Treatment Services Rider."
- **Mastectomy.** We added a definition of mastectomy to the "Reconstructive Surgery Services" section of the *EOC* and clarified that Members who have undergone mastectomy are entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998.
- **Maternal diabetes management.** We updated the *Benefit Summary* and *EOC* documents to clarify that medication and supplies for maternal diabetes management are covered at no cost share.
- **Mental health and substance use disorder benefits.** We revised the "Mental Health Services" and "Substance Use Disorder Services" sections of the *EOC* to more accurately reflect how we administer these benefits.
  - Both sections now clearly state that we cover diagnoses listed in the current *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association.
  - We removed the covered provider licensing type list in the "Mental Health Services" section because the list had the appearance of excluding other providers who are licensed to provide covered services.
  - We also removed the crisis intervention, evaluation and treatment list from the "Mental Health Services" section because the list could be interpreted as limiting or restricting coverage.
  - We reorganized the sequence of content in the "Substance Use Disorder Services" section so that the benefit description is more aligned with the revised "Mental Health Services" section.
- **Professional Services for evaluation, fitting, and follow-up care for contact lenses.** We modified this exclusion in the *EOC* to clarify that these Services, while generally excluded, may be covered under

the "Pediatric Vision Hardware and Optical Services Rider" or "Adult Vision Hardware and Optical Services Rider" if the coverage is purchased by the Group.

- **Travel Immunizations.** We revised this exclusion in the *EOC* to clarify that only travel-related immunizations for yellow fever, typhoid, and Japanese encephalitis are excluded rather than all travel services.

Other changes or clarifications

- **Chemical dependency.** The term "chemical dependency" has been replaced with "Substance Use Disorder" throughout the *EOC* and *Benefit Summary* to align with the predominant terminology.
- **Cost-Estimator tool.** We enhanced the "What you Pay" section in the *EOC*, directing Members to a cost estimator tool on **kp.org** for assistance with planning estimated costs of Services.
- **Dependents.** We revised the "Premium, Eligibility, and Enrollment" section of the *EOC* to include foster children and children newly placed for foster care as eligible dependents.
- **Disabled dependents.** We added a reference to disabled dependents in the "Dependent Limiting Age" definition to clarify that while we require most dependents to be under the Dependent Limiting Age in order to enroll and remain enrolled, this does not apply to Spouses and disabled dependents.
- **External Review.** We revised the "External Review" section of the *EOC* to reflect Oregon regulation allowing the Member to initiate a request for external review and subsequently provide a waiver form enabling us to disclose their protected health information. In addition, the section informs Members that they have five business days to submit additional information to the independent review organization during the external review process.
- **How to Obtain Services.** In the *EOC* for traditional, deductible and high deductible plans, we updated the link for Members to use to search for providers and care locations to **kp.org/doctors**.
- **MedImpact Pharmacy**. For Added Choice®, PPO Plus®, and Dual Choice PPO® plans, the definition of MedImpact Pharmacy has been revised to include the full name of the pharmacy sub-network.
- **"No-Fault Insurance" definition.** We added a definition of "no-fault insurance" to the "Injuries or Illnesses Alleged to be Caused by Other Parties or Covered by No-Fault Insurance" section of the *EOC*.
- **Non-Urgent Pre-Service claims.** We added an email option for Members to use to request a pre-service benefit determination, and updated the department name and phone number for Members who prefer to call us or mail their pre-service claim to us.
- **Preventive Care Services additional information.** We updated the *EOC* "Preventive Care Services" section with a more direct link **kp.org/prevention**, to help Members access additional information about these benefits and services.
- **Primary care and specialty care office visits.** We removed the parenthetical clause after "Primary care visit" and "Specialty care visit" in the "Outpatient Services" section of the *Benefit Summary*. This language gave examples of types of office visits, or services that could be provided during an office visit, such as health education services. Because the listed examples are services that are addressed elsewhere in the *EOC* or *Benefit Summary*, we removed them from the primary care and specialty care office visit rows to reduce the potential for confusion about the cost share.
- **Urgent Care.** We modified the "Urgent Care" section in the *EOC* for traditional, deductible and high deductible plans for consistency with other products, and added a link to **kp.org/getcare** for Members to find nearby urgent care locations.

- **Utilization Review criteria**. In the "Prior Authorization Review Requirements" section of the *EOC*, the department name and phone number for Members to request Utilization Review criteria has been updated so that any reference to contacting Member Relations has been changed to either Member Services or Customer Service, depending on the plan.
- **Workers' Compensation or Employer's Liability.** We simplified the language in the "Workers' Compensation or Employer's Liability" section of the *EOC* to make it clear that we will provide covered services even if it is unclear whether or not the Member is entitled to a payment or settlement.

Changes and clarifications that apply to medical benefit riders

Benefit clarifications

- **Infertility Treatment Services rider.** We modified the rider exclusions to clarify that we cover procurement and storage of the Member's own semen or eggs when used for their covered infertility treatment services. We also clarified that we cover ovum transplant (transfer) associated with a covered assisted reproductive technology procedure, such as in vitro fertilization (IVF).
- **Outpatient Prescription Drug rider.** We revised the "Outpatient Prescription Drug Rider Limitations" section to clarify that Members can refill most prescriptions when they have used at least 70% of the quantity.
- **Travel Immunization rider.** We changed the Travel Services Rider title to "Travel Immunizations Rider" and modified the language to more accurately reflect that the rider only covers travel-related immunizations for yellow fever, typhoid, and Japanese encephalitis.

Changes and clarifications that apply to dental plans

Benefit changes

- **Emergency visit cost share.** We removed the $25 emergency dental visit cost share from the *Benefit Summary* and any references to this additional cost share are also removed from the *EOC*. Effective January 1, 2023, Members will no longer have an additional $25 cost share for dental emergency or urgent care visits at Kaiser Permanente dental offices.
- **Tooth restoration (fillings).** For Dental Choice PPO dental plans, we enhanced the benefit for amalgam and composite fillings. The benefit limit has changed from once per tooth every 36 months to once per tooth surface every 24 months.

Benefit clarifications

- **Dental x-rays.** We clarified the benefit coverage for dental x-rays in the Dental Choice PPO plan *EOC*. Covered x-rays include one full mouth complete series or one panoramic radiographic image every 3 years, supplementary bite wing series once a year, and periapical x-rays and occlusal x-rays as necessary based on the dentist's assessment of the Member's oral health and risk factors.

Other changes or clarifications

- **Dental Third-Party Administrator change.** Effective January 1, 2023, SKYGEN USA will no longer be our third-party administrator for our Dental Choice plan benefits. References to SKYGEN have been replaced with "we," "us," and Dental Choice Customer Service.

- **Dependents.** We revised the "Premium, Eligibility, and Enrollment" section of the *EOC* to include foster children and children newly placed for foster care as eligible dependents.
- **How to Obtain Services.** In the *EOC* for Dental Choice PPO plans, we updated the link for Members to use to search for participating providers to **kp.org/dental/nw/ppo**.

Changes and clarifications that apply to Senior Advantage plans

For the first time in many years, the Centers for Medicare and Medicaid Services (CMS) made structural changes (e.g. length, formatting) to the model documents used by Medicare Advantage Organizations, such as Kaiser Permanente. The substance primarily remains the same, but there are numerous changes for the 2023 documents including: increased use of plain language, elimination of duplicative language, elimination of some tables, elimination of some Tables of Contents, general reorganization of topics, and fewer pages.

In light of the extensive changes, we selected several items below that may be of most interest.

Benefit changes or clarifications

- **Cardiac and pulmonary rehab therapies cost share cap.** CMS sets annual cost sharing limits for certain benefits, and they reduced the cost share limit for pulmonary rehabilitation from $30 to $20 for 2023. Kaiser Permanente is applying this new cost share cap to cardiac rehabilitation, pulmonary rehabilitation and supervised exercise therapy (SET) visits. Members in our Senior Advantage plans won't pay more than $20 per visit for these outpatient visits.
- **Durable medical equipment (DME) and related supplies – glucose monitors and oxygen equipment.** We added non-therapeutic continuous glucose monitors and supplies to the list of DME items that are covered at no charge. In addition, information about the Member's cost sharing for home oxygen equipment was moved from Chapter 3 of the *EOC* to the DME section of the Medical Benefits Chart. The Member cost sharing (20% coinsurance) has not changed.
- **Fitness benefit (the Silver&Fit® Healthy Aging and Exercise Program).** The list of Silver&Fit online services has been updated to include on-demand workout videos, Workout Plans, the Well-Being Club, and a newsletter. The Well-Being Club is an enhanced feature of the Silver&Fit website that gives Members the opportunity to view customized resources as well as attend live-streaming classes and events.
- **Hearing services.** We clarified that evaluation and fitting for hearing aids is covered only if the Member is enrolled in a plan with a hearing aid benefit.
- **Hospice care.** We added more detail to the description of the hospice care benefit to let Members know that we will help them find a Medicare-certified hospice program in the plan's service area; and also explaining that when a Member is admitted to a hospice, they may choose to stay in their Medicare Advantage plan and, if so, must continue to pay plan premiums.
- **Insulin cost share cap.** Effective January 1, 2023, Members enrolled in our Senior Advantage plans won't pay more than $35 for each one-month supply of insulin, no matter what drug tier the insulin product is on. This change is as a result of the Inflation Reduction Act of 2022.
- **Screening for lung cancer.** We modified the age range and smoking history criteria for screening individuals for lung cancer with low dose computed tomography (LDCT). Eligible Members are people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years.

- **Telehealth services.** We added podiatry to the list of covered telehealth services in the physician/practitioner services section of the Medical Benefits Chart. This section was also modified to provide more detail about telehealth services for diagnosis, evaluation, and treatment of mental health disorders.

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation

Portland, Oregon

Large Group Senior Advantage Plan with Part D Group Agreement

Group Name: Multnomah County Employees

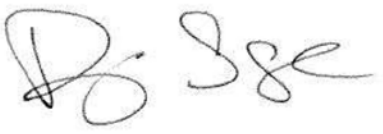
Group Number: 1569 – 499

Term of *Agreement*

1/1/2023, through 12/31/2023

Anniversary date

January 1



Authorized representative

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KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST

A Nonprofit Corporation

Group Agreement

INTRODUCTION

This *Group Agreement* (*Agreement*), including the Large Group Senior Advantage *Evidence of Coverage* (*EOC*) incorporated herein by reference, and any amendments, constitutes the contract between Kaiser Foundation Health Plan of the Northwest (Health Plan) and Multnomah County Employees (Group). In this *Agreement,* some capitalized terms have special meaning; please see the "Definitions" section in the *EOC* document for terms you should know.

To be eligible under this *Agreement*, the Group must meet the underwriting requirements set forth in Health Plan's Rate Assumptions and Requirements document.

PREMIUM

Only Members for whom Health Plan has received the appropriate Premium payment listed below are entitled to coverage under this *Agreement*, and then only for the period for which Health Plan has received appropriate payment.

Monthly Premium Amounts

Medicare as Primary Payer

For each Member eligible for benefits under Part A, enrolled in Part B, and eligible for Part D of Medicare who has enrolled in Kaiser Permanente Senior Advantage with Part D: $398.16

Medicare as Secondary Payer

Members who are eligible and enrolled in Medicare Part A or B and for whom Medicare is secondary payer are subject to the same Premium amounts and receive the same benefits as Members who are not eligible for Medicare. Members who are eligible and enrolled in Medicare Parts A and B as secondary payer and who meet applicable eligibility requirements may also enroll in a Kaiser Permanente Senior Advantage plan. These Members receive the coverages described in both the non-Medicare plan and the Senior Advantage plan, and the Premium amounts for these Members are the Premium amounts for the non-Medicare plan.

For each Member eligible for benefits under Part A, enrolled in Part B, and eligible for Part D of Medicare who has enrolled in Kaiser Permanente Senior Advantage with Part D: $637.92

TERM OF *AGREEMENT*, ACCEPTANCE OF *AGREEMENT*, AND RENEWAL

Term of *Agreement*

Unless terminated as set forth in the "Termination of *Agreement*" section, this *Agreement* is effective for the term shown on the cover page.

Acceptance of *Agreement*

Group will be deemed as having accepted this *Agreement* and any amendments issued during the term of this *Agreement.*

Group may not change this *Agreement* by adding or deleting words, and any such addition or deletion is void. If Group wishes to change anything in this *Agreement*, Group must contact its Health Plan account manager. Health Plan might not respond to any changes or comments that Group may submit. Group may not

construe Health Plan's lack of response to any submitted changes or comments to imply acceptance. Health Plan will issue a new agreement or amendment if Health Plan and Group agree on any changes.

Renewal

This *Agreement* is guaranteed renewable, but does not automatically renew. If Group complies with all of the terms of this *Agreement,* Health Plan will offer to renew this *Agreement,* upon not less than 30 days prior written notice to Group, either by sending Group a new group agreement to become effective immediately after termination of this *Agreement,* or by extending the term of this *Agreement* pursuant to "Amendments Effective on Anniversary Date" in the "Amendment of *Agreement*" section. The new or extended group agreement will include a new term of agreement and other changes. If Group does not renew this *Agreement*, Group must give Health Plan written notice as described under "Termination on Notice" in the "Termination of *Agreement*" section.

AMENDMENT OF *AGREEMENT*

Amendments Effective on Anniversary Date

Upon not less than 30 days prior written notice to Group, Health Plan may extend the term of this *Agreement* and make other changes by amending this *Agreement* effective on the anniversary date of any year (see cover page for anniversary date).

Amendment due to Tax or Other Charges

If during the term of this *Agreement* a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Health Plan, Medical Group, or Kaiser Foundation Hospitals or upon any activity of any of them, then upon 31 days prior written notice, Health Plan may increase Group's Premium to include Group's share of the new or increased tax or charge.

Amendment Due to Medicare Changes

Health Plan contracts on a calendar year basis with the Centers for Medicare and Medicaid Services to offer Kaiser Permanente Senior Advantage. Health Plan may amend this *Agreement* to change any Senior Advantage *EOCs* and Premiums effective January 1 of any year (unless the federal government requires or allows a different effective date). The amendment may include an increase or decrease in Premiums and benefits (including Member cost sharing and the Medicare Part D initial and catastrophic coverage levels). Health Plan will give Group written notice of any such amendment.

Other Amendments

Health Plan may amend this *Agreement* at any time by giving written notice to Group, in order to (a) address any law or regulatory requirement; (b) reduce or expand the Health Plan Service Area; or (c) increase any benefits of any Medicare product approved by the Centers for Medicare and Medicaid Services (CMS), if applicable to this *Agreement.*

TERMINATION OF *AGREEMENT*

This *Agreement* will terminate under any of the conditions listed in this "Termination of *Agreement*" section. All rights to benefits under this *Agreement* end at 11:59 p.m. PST on the termination date, except as expressly provided in the "Ending your membership in our plan" section of *the EOC.*

If this *Agreement* terminates and Group does not replace this coverage with another plan, Health Plan will give Group written notice of termination not later than 10 working days after the termination date and will explain the rights of Members regarding continuation of coverage as provided by federal and state law.

If Health Plan fails to give notice as required, this *Agreement* shall continue in effect from the date notice should have been given until the date the Group receives the notice. Health Plan will waive the Premium for the period for which coverage is continued and the time period within which Member may exercise any right to continuation shall commence on the date that Group receives the notice. Health Plan will properly notify Members of their right to continuation of coverage under federal and state law.

Termination on Notice

Group may terminate this *Agreement* by giving prior written notice to Health Plan not less than 30 days prior to the termination date and remitting all amounts payable relating to this *Agreement*, including Premium, for the period through the termination date.

Termination for Fraud

Health Plan may terminate this *Agreement* by giving at least 30 days prior written notice to Group, if Group commits fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan. For example, an intentional misrepresentation of material fact occurs if Group intentionally furnishes incorrect or incomplete material information to Health Plan or is aware that incorrect or incomplete material information has been provided to Health Plan on enrollment or other Health Plan forms.

Termination for Violation of Contribution or Participation Requirements

Health Plan may terminate this *Agreement* upon 31 days prior written notice to Group, if Group fails to comply with Health Plan's contribution or participation requirements (including those listed in the "Contribution and Participation Requirements" section).

Termination for Discontinuance of a Product or all Products within a Market

Health Plan may terminate a particular product or all products offered in the group market as permitted by law.

Health Plan may terminate this *Agreement* if it ceases to write new business in the group market in Oregon or in a specific service area within Oregon, or elects not to renew all of its group plans in Oregon or in a specific service area within Oregon, or both cease offering and cease renewing all products in Oregon or a specific service area in Oregon, if Health Plan fails to reach an agreement with health care providers. To discontinue all products, Health Plan must: (a) notify the Director of the Department of Consumer and Business Services and all Groups; and (b) not cancel coverage for 180 days after the date of notice to the Director and Groups.

Health Plan may terminate this *Agreement* if it elects not to offer or renew, or offer and renew, this type of plan in Oregon or within a specific service area within Oregon. Except as provided below regarding failure to reach agreement with providers, in order to discontinue a product, Health Plan must: (a) cease to offer and/or cease to renew this plan for all groups; (b) offer (in writing) to each group covered by this plan, enrollment in any other plan offered by Health Plan in the group market, not less than 90 days prior to discontinuance; and (c) act uniformly without regard to claims experience of affected groups or the health status of any current or prospective Member.

Health Plan may terminate this *Agreement* if the Director of the Department of Consumer and Business Services orders Health Plan to discontinue coverage upon finding that continuation of coverage (a) would not be in the best interests of the Members; or (b) would impair Health Plan's ability to meet its contractual obligations.

Health Plan may terminate this *Agreement* by providing not less than 90 days prior written notice if there are no Members covered under this *Agreement* who reside or work in the Service Area.

Health Plan may terminate this *Agreement* if it is unable to reach an agreement with the health care providers to provide Services within a specific service area. Health Plan must: (a) cease to offer and cease to renew this plan for all groups within the service area; and (b) not less than 90 days prior to discontinuance, notify the Director of the Department of Consumer and Business Services and each group in that service area of the decision to discontinue offering the plan(s) and offer all other group plans available in that service area.

CONTRIBUTION AND PARTICIPATION REQUIREMENTS

No change in Group's contribution or participation requirements is effective for purposes of this *Agreement* unless Health Plan consents in writing.

Group must:

- Meet all underwriting requirements set forth in Health Plan's Rate Assumptions and Requirements document.
- With respect to all persons entitled to coverage under Group's plan(s), offer enrollment in Health Plan to all such persons on conditions no less favorable than those for any other plan available through Group.
- Permit Health Plan to examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement.*
- Comply with Centers for Medicare and Medicaid Services (CMS) requirements governing enrollment in, and disenrollment from, Kaiser Permanente Senior Advantage.

SUBSCRIBER CONTRIBUTIONS FOR MEDICARE PART C AND PART D COVERAGE

Medicare Part C Coverage

This "Subscriber Contributions for Medicare Part C Coverage" section applies to Group's Kaiser Permanente Senior Advantage coverage. Group's Senior Advantage Premiums include the Medicare Part C premium for coverage of items and services covered under Parts A and B of Medicare, and supplemental benefits. Group may determine how much it will require Subscribers to contribute toward the Medicare Part C premium for each Senior Advantage Member in the Subscriber's Family, subject to the following restrictions:

- If Group requires different contribution amounts for different classes of Senior Advantage Members for the Medicare Part C premium, then Group agrees to the following:
  - Any such differences in classes of Members are reasonable and based on objective business criteria, such as years of service, business location, and job category.
  - Group will not require different Subscriber contributions toward the Medicare Part C premium for Members within the same class.
- Group will not require Subscribers to pay a contribution for Medicare Part C coverage for a Senior Advantage Member that exceeds the Medicare Part C premium for items and services covered under Parts A and B of Medicare, and supplemental benefits. As applicable, Health Plan will pass through monthly payments received from CMS (the monthly payments described in 42 C.F.R. 422.304(a)) to reduce the amount the Member contributes toward the Medicare Part C premium.

Medicare Part D Coverage

This "Subscriber Contributions for Medicare Part D Coverage" section applies only to Group's Kaiser Permanente Senior Advantage coverage that includes Medicare Part D prescription drug coverage. Group's Senior Advantage monthly Premium includes the Medicare Part D premium. Group may determine how

much it will require subscribers to contribute toward the Medicare Part D premium for each Senior Advantage Member in the Subscriber's Family, subject to the following restrictions:

- If Group requires different contribution amounts for different classes of Senior Advantage Members for the Medicare Part D premium, then Group agrees to the following:
  - Any such differences in classes of Members are reasonable and based on objective business criteria, such as years of service, business location, and job category, and are not based on eligibility for the Medicare Part D Low Income Subsidy (the subsidies described in 42 C.F.R. Section 423 Subpart P, which are offered by the Medicare program to certain low-income Medicare beneficiaries enrolled in Medicare Part D, and which reduce the Medicare beneficiaries' Medicare Part D premiums and/or Medicare Part D cost-sharing amounts).
  - Group will not require different subscriber contributions toward the Medicare Part D premium for Members within the same class.
- Group will not require subscribers to pay a contribution for prescription drug coverage for a Senior Advantage Member that exceeds the Premium for prescription drug coverage (including the Medicare Part D premium). The Group will pass through direct subsidy payments received from CMS to reduce the amount the Member contributes toward the Medicare Part D premium.
- Health Plan will credit Group with any Low Income Subsidy amounts that Health Plan receives from CMS for Group's Members and Health Plan will identify those Members for Group as required by CMS. For those Members, Group will first credit the Low Income Subsidy amount toward the Subscriber's contribution for that Member's Senior Advantage Premium for the same month, and will then apply any remaining portion of the Member's Low Income Subsidy toward the portion of the Senior Advantage Premium that is paid on behalf of that Member for that month. If Group is unable to reduce the Subscriber's contribution before the Subscriber makes the contribution, Group shall, consistent with CMS guidance, refund the Low Income Subsidy amount to the Subscriber (up to the amount of the Subscriber Premium contribution for the Member for that month) within 45 days after the date Health Plan receives the Low Income Subsidy amount from CMS. Health Plan reserves the right to periodically require Group to certify that Group is either reducing Subscribers' monthly Premium contributions or refunding the Low Income Subsidy amounts to Subscribers in accord with CMS guidance.
- For any Members who are eligible for the Low Income Subsidy, if the amount of that Low Income Subsidy is less than the Member's contribution for the Medicare Part D premium, then Group should inform the Member of the financial consequences of the Member's enrolling in the Member's current coverage, as compared to enrolling in another Part D plan with a Premium equal to or less than the Low Income Subsidy amount.

Late enrollment penalty. If any Members are subject to the Medicare Part D late enrollment penalty, Premiums for those Members will increase to include the amount of the penalty.

MISCELLANEOUS PROVISIONS

Administration of *Agreement*

Health Plan may adopt policies, procedures, rules, and interpretations to promote efficient administration of this *Agreement.*

Assignment

Health Plan may assign this *Agreement.* Group may not assign this *Agreement* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Health Plan's prior written consent. This *Agreement* shall be binding on the successors and permitted assignees of Health Plan and Group.

Attorney Fees and Costs

If Health Plan or Group institutes legal action against the other to collect any sums owed under this *Agreement*, the party that substantially prevails will be reimbursed for its reasonable costs of collection, including attorneys' fees, by the other party.

Governing Law

Except as preempted by federal law, this *Agreement* will be governed in accord with Oregon law and any provision that is required to be in this *Agreement* by state or federal law shall bind Group and Health Plan regardless of whether that provision is set forth in this *Agreement.*

Group Delegation to Health Plan of Administrative Billing Functions

Group hereby delegates to Health Plan the following administrative billing functions:

- Billing and collecting Premiums under this *Agreement.*
- Terminating the memberships of Group's Members for nonpayment of Premiums.

Group retains all other responsibilities, such as meeting applicable contribution and participation requirements and distributing information about coverage to potential Subscribers before enrollment.

When an employee becomes eligible for retiree coverage through Group in Health Plan, Group will notify Health Plan of the enrollment and the effective date. Health Plan will then bill and collect Premium from the Subscriber.

Group will notify Health Plan when a Member's membership terminates, except for terminations that Health Plan initiates, for example termination for nonpayment of Premium or termination for cause in accord with Chapter 10, Section 5 ("We must end your membership in our plan in certain situations") of the *EOC* for Senior Advantage.

Health Plan will send Group a monthly report of membership status that includes the names of all Members who are currently enrolled and the memberships that Health Plan has terminated for nonpayment during the prior month.

No Waiver

Health Plan's failure to enforce any provision of this *Agreement* will not constitute a waiver of that or any other provision, or impair Health Plan's right thereafter to require Group's strict performance of any provision.

Notices

Notices must be sent to the addresses listed below, except that Health Plan or Group may change its address for notices by giving written notice to the other. Notices are deemed given when delivered in person, sent via email, or deposited in a U.S. Postal Service receptacle for the collection of U.S. mail.

Notices from Health Plan to Group will be sent to:

Group Contact	Tami Mahrt
Group Name	Multnomah County Employees
Group Address	Employee Benefits
Group Address	501 SE Hawthorne Blvd Ste 400
Group Address	Portland, OR 97214

Producer Contact	Jennifer Chisholm
Producer Name	Mercer Health & Benefits LLC of Portland
Producer Address	4565 Paysphere Circle
Producer Address	
Producer Address	Chicago, IL 60674

Note: when Health Plan sends Group a new (or renewed) group agreement, Health Plan will enclose a summary that discusses the changes Health Plan has made to this *Agreement.* Groups that want information about changes before receiving the new group agreement may request advance information from Group's Health Plan account manager. Also, if Group designates in writing a third party such as a "Producer of Record," Health Plan may send the advance information to the third party rather than to Group (unless Group requests a copy also).

Notices from Group to Health Plan regarding billing and enrollment must be sent to:

Kaiser Foundation Health Plan of the Northwest
P.O. Box 23127
San Diego, CA 92193
Or emailed to: csc-den-roc-group@kp.org

Notices from Group to Health Plan regarding Premium payments must be sent to:

Kaiser Foundation Health Plan of the Northwest
PO Box 34178
Seattle, WA 98124

Notices from Group to Health Plan regarding termination of this *Agreement* must be sent to the Group's account manager at:

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah Street, Suite 100
Portland, OR 97232

Reporting Membership Changes and Retroactivity

Health Plan's billing statement to Group explains how to report membership changes. Group's Kaiser Permanente account manager can also provide Group with this information. Group must report membership changes (including sending Health Plan-approved membership forms) within the time limit for retroactive changes. Except for Senior Advantage membership terminations discussed below, the time limit for retroactive membership changes is the calendar month when Health Plan's San Diego Service Center receives Group's notification of the change plus the previous two months unless Health Plan agrees otherwise in writing.

Involuntary Kaiser Permanente Senior Advantage Membership Terminations

Group must give Health Plan's Denver Service Center 30 days prior written notice of Senior Advantage involuntary membership terminations. An involuntary Kaiser Permanente Senior Advantage membership termination is a termination that is not in response to a disenrollment notice issued by CMS to Health Plan or received by Health Plan directly from a Member (these events are usually in response to a Member's request for disenrollment to CMS because the Member has enrolled in another Medicare health plan or wants Original Medicare coverage or has lost Medicare eligibility). The membership termination date is the first of the month following 30 days after the date when Health Plan's Denver Service Center receives a Senior Advantage membership termination notice unless Group specifies a later termination date. For example, if Health Plan's Denver Service Center receives a termination notice on March 5 for a Senior Advantage

Member, the earliest termination date is May 1 and Member is required to pay applicable Premiums for the months of March and April.

Voluntary Kaiser Permanente Senior Advantage Membership Terminations

If Health Plan's Denver Service Center receives a disenrollment notice from CMS or a membership termination from the Member, the Kaiser Permanente Senior Advantage membership termination date will be in accord with CMS requirements.

Social Security and Tax Identification Numbers

Within 60 days after Health Plan sends Group a written request, Group will send Health Plan a list of all Members covered under this *Agreement,* along with the following:

- The Member's Social Security number.
- The tax identification number of the employer of the Subscriber in the Member's Family.
- Any other information that Health Plan is required by law to collect.

Medical Benefits Chart: Senior Advantage with Part D

Multnomah County Employees
1569 - 499

For group benefits effective 1/1/2023 through 12/31/2023

You will see this apple next to the preventive services in this Medical Benefits Chart.

Services that are covered for you	What you must pay when you get these services
Maximum out-of-pocket amount	**$600**
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain† Covered services include: • Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: ♦ For the purpose of this benefit, chronic low back pain is defined as: o Lasting 12 weeks or longer. o Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.). o Not associated with surgery. o Not associated with pregnancy. An additional eight sessions are covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements.	**$10 per visit**

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

Services that are covered for you	What you must pay when you get these services
Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • A master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • A current, full, active, and unrestricted license to practice acupuncture in a state, territory, or commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by regulations at 42 CFR §§ 410.26 and 410.27.	
Alternative care therapies (self-referred)	
• Acupuncture services **(up to 20 visits per Year)**	**$15 per visit** (If covered, see the Acupuncture Services Rider in the **EOC** for additional information.)
• Chiropractic services **(up to 20 visits per Year)**	**$15 per visit** (If covered, see the Chiropractic Services Rider in the **EOC** for additional information.)
• Massage therapy **(up to 12 visits per Year)**	**$25 per visit** (If covered, see the Massage Therapy Rider in the **EOC** for additional information.)
• Naturopathic medicine	**$10** (If covered, see the Naturopathic Medicine Rider in the **EOC** for additional information.)

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

Services that are covered for you	What you must pay when you get these services
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. • We also cover the services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) if you reasonably believe that you have an emergency medical condition and you reasonably believe that your condition requires the clinical support of ambulance transport services. • †Nonemergency transportation by ambulance if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	**$50** per one-way trip
Annual routine physical exams Routine physical exams are covered if the exam is medically appropriate preventive care in accord with generally accepted professional standards of practice.	There is no coinsurance, copayment, or deductible for this preventive care.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.

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

Services that are covered for you	What you must pay when you get these services
medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39. • One screening mammogram every 12 months for women aged 40 and older. • Clinical breast exams once every 24 months.	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services† Comprehensive programs for cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**$10** per visit
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months. • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past three years: one Pap test every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.

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

Services that are covered for you	What you must pay when you get these services
Chiropractic services† Covered services include: • We cover only manual manipulation of the spine to correct subluxation. ♦ These Medicare-covered services are provided by a network chiropractor. For the list of network chiropractors, please refer to the **Provider Directory**.	**$10 per visit**
Colorectal cancer screening • For people 50 and older, the following are covered: ♦ Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. ♦ One of the following every 12 months: o Guaiac-based fecal occult blood test (gFOBT). o Fecal immunochemical test (FIT). • DNA-based colorectal screening every 3 years. • For people at high risk of colorectal cancer, we cover a screening colonoscopy (or screening barium enema as an alternative) every 24 months. • For people not at high risk of colorectal cancer, we cover a screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.
• Procedures performed during a screening colonoscopy (for example, removal of polyps). • Colonoscopies following a positive gFOBT or FIT test or a flexible sigmoidoscopy screening. • **Note:** All other colonoscopies are subject to the applicable cost-sharing listed elsewhere in this chart.	**$0**
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.

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

Services that are covered for you	What you must pay when you get these services
triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	
Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and noninsulin users), covered services include: • †Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices, lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.	**$0**
• †For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the noncustomized removable inserts provided with such shoes). Coverage includes fitting.	**$0**
Diabetes self-management training is covered under certain conditions.	**$0**
Durable medical equipment (DME) and related supplies† (For a definition of "durable medical equipment," see Chapter 12 as well as Chapter 3, Section 7, of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech-generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they	• **$0** for ultraviolet light therapy equipment for psoriasis treatment, CADD pumps, bone/spine stimulators, ventilators and enteral pumps/supplies, and non-therapeutic continuous glucose monitor and supplies • **$0** for all other DME **Oxygen equipment** Your cost sharing for Medicare oxygen equipment coverage is **20%**, every time you receive equipment.

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

Services that are covered for you	What you must pay when you get these services
can special order it for you. The most recent list of suppliers is available on our website at **kp.org/directory**. We also cover the following DME not covered by Medicare when medically necessary: • Bed accessories when bed extension is required. • Non-therapeutic continuous glucose monitor and supplies if patient meets criteria for coverage. • Iontophoresis device to treat hyperhidrosis when antiperspirants are contraindicated and the hyperhidrosis has created medical complications or is preventing daily living activities. • Resuscitation bag if tracheostomy patient has significant secretion management problems, needing lavage and suction technique aided by deep breathing via resuscitation bag.	Your cost sharing will not change after being enrolled for 36 months.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. **You have worldwide emergency care coverage.**	**$50** per Emergency Department visit This copayment does not apply if you are immediately admitted directly to the hospital as an inpatient (it does apply if you are admitted to the hospital as an outpatient; for example, if you are admitted for observation). †If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost-sharing you would pay at a network hospital.
Fitness benefit (the Silver&Fit® Healthy Aging and Exercise Program) The Silver&Fit program includes the following:	**$0**

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

Services that are covered for you	What you must pay when you get these services
• You can join a participating Silver&Fit fitness center and take advantage of the services that are included in the fitness center's standard membership (for example, use of fitness center equipment or instructor-led classes that do not require an additional fee). If you sign-up for a Silver&Fit fitness center membership, the following applies: ♦ The fitness center provides facility and equipment orientation. ♦ Services offered by fitness centers vary by location. Any nonstandard fitness center service that typically requires an additional fee is not included in your standard fitness center membership through the Silver&Fit program (for example, court fees or personal trainer services). ♦ To join a participating Silver&Fit fitness center, register through **kp.org/SilverandFit** and select your location(s). You can then print or download your "Welcome Letter," which includes your Silver&Fit card with fitness ID number to provide to the selected fitness center. ♦ Once you join, you can switch to another participating Silver&Fit fitness center once a month and your change will be effective the first of the following month (you may need to complete a new membership agreement at the fitness center). • If you would like to work out at home, you can select one Home Fitness Kit per calendar year. There are many Home Fitness Kits to choose from, including Wearable Fitness Tracker, Pilates, Strength, Swim, and Yoga Kit options. Kits are subject to change and once selected cannot be exchanged. • To pick your kit, please visit **kp.org/SilverandFit** or call Silver&Fit customer service. • Access to Silver&Fit online services at **kp.org/SilverandFit** that provide on-demand workout videos, Workout Plans, the Well-Being Club, a newsletter, and other helpful features. The Well-Being Club enhanced feature of the Silver&Fit website allows members the opportunity to view customized resources as well as attend live-streaming classes and events.	

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

Services that are covered for you	What you must pay when you get these services
For more information about the Silver&Fit program and the list of participating fitness centers and home kits, visit **kp.org/SilverandFit** or call Silver&Fit customer service at **1-877-750-2746** (TTY **711**), Monday through Friday, 5 a.m. to 6 p.m. (PST). The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a federally registered trademark of ASH and used with permission herein. Participating fitness centers and fitness chains may vary by location and are subject to change.	
Health and wellness education programs Health and wellness programs include weight management, quitting tobacco, diabetes management, life care planning, prediabetes, and more. Registered dietitians, health coaches, certified diabetes educators, and other health professionals facilitate our classes. We offer in-person, online, and phone options to fit your learning style. Please see our health and wellness classes and resources catalog at **kp.org/healthylivingcatalog/nw**. Contact Member Services for more details or to request a copy of our catalog.	**$0**
Hearing services • Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. • Routine hearing exams.	**$20** per visit
• *Hearing aids, including evaluation and fitting.	**Balance after $4,000 allowance is applied for each hearing aid per ear every four years** (If covered, see the Hearing Aid Rider in the **EOC** for additional information.)
HIV screening • For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover one screening exam after each exposure.	There is no coinsurance, copayment, or deductible for members eligible for

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

Services that are covered for you	What you must pay when you get these services
• For women who are pregnant, we cover up to three screening exams during a pregnancy.	Medicare-covered preventive HIV screening.
Home-based palliative care† Services not covered by Medicare in the home are provided in the form of palliative care to diminish symptoms of terminally ill members with a life expectancy of 7–12 months. Services include non-Medicare-covered palliative nursing and social work services in the home.	**$0**
Home health agency care† Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services. To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week. • Physical therapy, occupational therapy, and speech therapy. • Medical and social services. • Medical equipment and supplies.	**$0** **Note:** There is no cost-sharing for home health care services and items provided in accord with Medicare guidelines. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply if the item is covered under a different benefit; for example, durable medical equipment not provided by a home health agency.
Home infusion therapy† Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care. • Patient training and education not otherwise covered under the durable medical equipment benefit.	**$0** for professional services, training, and monitoring. The components (such as, Medicare Part B drugs, DME, and medical supplies) needed to perform home infusion may be subject to the applicable cost-sharing listed elsewhere in this Medical Benefits Chart depending on the item.

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

Services that are covered for you	What you must pay when you get these services
• Remote monitoring. • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	
We cover home infusion supplies and drugs if all of the following are true: • Your prescription drug is on our Medicare Part D formulary. • We approved your prescription drug for home infusion therapy. • Your prescription is written by a network provider and filled at a network home-infusion pharmacy.	**$0** **Note:** If a covered home infusion supply or drug is not filled by a network home-infusion pharmacy, the supply or drug may be subject to the applicable cost-sharing listed elsewhere in this document depending on the service.
Home medical care not covered by Medicare (acute care at home)† **This benefit is unavailable to members in Lane County.** We cover medical care in your home that is not otherwise covered by Medicare in certain situations to provide you with an alternative to receiving acute care in a hospital. Services in the home must be: • Prescribed by a network hospitalist who has determined that based on your health status, treatment plan, and home setting that you can be treated safely and effectively in the home. • Elected by you because you prefer to receive the care described in your treatment plan in your home. Medically Home is our network provider and will provide the following services and items in your home in accord with your treatment plan for as long as they are prescribed by a network hospitalist: • Home visits by RNs, physical therapists, occupational therapists, speech therapists, respiratory therapists, nutritionist, home health aides, and other healthcare professionals in accord with the home care treatment plan and the provider's scope of practice and license. • Communication devices to allow you to contact Medically Home's command center 24 hours a day, 7 days a week. This includes needed communication technology to support reliable communication, and a PERS alert device	**$0**

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

Services that are covered for you	What you must pay when you get these services
to contact Medically Home's command center if you are unable to get to a phone. • The following equipment necessary to ensure that you are monitored appropriately in your home: blood pressure cuff/monitor, pulse oximeter, scale, and thermometer. • Mobile imaging and tests such as X-rays and EKGs. • The following safety items: shower stools, raised toilet seats, grabbers, long handle shoehorn, and sock aid. • Meals while you are receiving acute care in the home.	
In addition, for Medicare-covered services and items listed below, the cost-sharing indicated elsewhere in this Medical Benefit Chart does not apply when the services and items are prescribed as part of your home treatment plan: • Durable medical equipment. • Medical supplies. • Ambulance transportation to and from network facilities when ambulance transport is medically necessary. • Physician assistant and nurse practitioner house calls. • The following services at a network facility if the services are part of your home treatment plan: ♦ Network Emergency Department visits associated with this benefit. The cost-sharing indicated elsewhere in this Medical Benefit Chart will apply to all other services and items that aren't part of your home treatment plan (for example, DME unrelated to your home treatment plan) or are part of your home treatment plan, but are not provided in your home except as listed above. **Note:** For prescription drug cost-sharing information, please refer to the Medicare Part B prescription drug section in this chart and Chapter 6 for Medicare Part D prescription drugs.	**$0**
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, **not** our plan.

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

Services that are covered for you	What you must pay when you get these services
program. Your plan is obligated to help you find Medicare-certified hospice programs in your plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief. • Short-term respite care. • Home care. When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan, you must continue to pay plan premiums. ***For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost-sharing. **For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:** If you need nonemergency, non–urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization): • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services. • *If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare). **For services that are covered by our plan but are not covered by Medicare Part A or B:** We will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal	

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

Services that are covered for you	What you must pay when you get these services
prognosis. You pay your plan cost-sharing amount for these services. **For drugs that may be covered by our plan's Part D benefit:** If these drugs are unrelated to your terminal hospice condition, you pay cost-sharing. If they are related to your terminal hospice condition, then you pay Original Medicare cost-sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4, "What if you're in Medicare-certified hospice." **Note:** If you need nonhospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	
We cover hospice consultation services for a terminally ill person who hasn't elected the hospice benefit.	**$0**
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine. • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary. • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B. • COVID-19 vaccine. • Other vaccines if you are at risk and they meet Medicare Part B coverage rules. We also cover some vaccines under our Part D prescription drug benefit.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.
Inpatient hospital care† Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. There is no limit to the number of medically necessary hospital days or services that are generally and customarily	**$50 per day up to $250 per admission** Thereafter there is no charge for the remainder of your covered hospital stay. You do not pay the copayment listed above for the day you are discharged unless you are admitted and discharged on the same day.

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

Services that are covered for you	What you must pay when you get these services
provided by acute care general hospitals. Covered services include, but are not limited to: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Costs of special care units (such as intensive care or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical, occupational, and speech language therapy. • Inpatient substance abuse services for medical management of withdrawal symptoms associated with substance abuse (detoxification). • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If we provide transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion, in accord with our travel and lodging guidelines, which are available from Member Services. • Blood—including storage and administration. • Physician services.	†If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. **Note:** If you are admitted to the hospital in 2022 and are not discharged until sometime in 2023, the 2022 cost-sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility.

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

Services that are covered for you	What you must pay when you get these services
Note: To be an "inpatient," your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient services in a psychiatric hospital† Covered services include mental health care services that require a hospital stay. • We cover up to 190 days per lifetime for inpatient stays in a Medicare-certified psychiatric hospital. The number of covered lifetime hospitalization days is reduced by the number of inpatient days for mental health treatment previously covered by Medicare in a psychiatric hospital. • The 190-day limit does not apply to mental health stays in a psychiatric unit of a general hospital.	**$50 per day up to $250 per admission** Cost-sharing is charged for each inpatient stay. You do not pay the copayment listed above for the day you are discharged unless you are admitted and discharged on the same day. **Note:** If you are admitted to the hospital in 2022 and are not discharged until sometime in 2023, the 2022 cost-sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility.
Inpatient stay: Covered services received in a hospital or SNF during a noncovered inpatient stay† If you have exhausted your inpatient mental health or skilled nursing facility (SNF) benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient or SNF stay. However, in some cases, we will cover certain services you receive while you are in the hospital or SNF. Covered services include, but are not limited to: • Physician services. • Diagnostic tests (like lab tests). • X-rays, radium, and isotope therapy, including technician materials and services. • Surgical dressings. • Splints, casts, and other devices used to reduce fractures and dislocations.	If your inpatient or SNF stay is no longer covered, we will continue to cover Medicare Part B services at the applicable cost-sharing listed elsewhere in this Medical Benefits Chart when provided by network providers.

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

Services that are covered for you	What you must pay when you get these services
• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes (including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition). • Physical therapy, speech therapy, and occupational therapy.	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew his or her order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs† These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:	Your applicable Part D prescription drug copayment or coinsurance

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* Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
• Drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan. • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant. • Certain oral anti-cancer drugs and anti-nausea drugs. • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases.	
• Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services.	**$0**
• Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug.	**$0**
• Antigens. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa).	**$0**
Note: • We also cover some vaccines under our Part B and Part D prescription drug benefit. • Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	
***Medicare Part D prescription drugs†** Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6 and listed here.	**$10 generic/$20 brand, for up to a 30-day supply, per prescription. When you get your drugs from our mail-order pharmacy, you may get up to a 31-90 day supply for two copayments. After you have paid $7,400 in true out-of-pocket costs for Part D covered drugs in a calendar year, you will pay the lesser of your copayment or $3 for**

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Services that are covered for you	What you must pay when you get these services
	generic drugs and $7 for brand drugs, per prescription. Insulin is subject to the applicable drug tier cost-sharing up to $35 for each 30-day supply.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services† Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following. services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable).	**$0** for clinically administered Medicare Part B drugs when provided by an Opioid Treatment Program
• Substance use counseling. • Individual and group therapy. • Toxicology testing. • Intake activities. • Periodic assessments.	**$20** per visit
Outpatient diagnostic tests and therapeutic services and supplies† Covered services include, but are not limited to: • Laboratory tests.	**$0 per department visit**
♦ INR lab tests for persons with liver disease or certain bleeding disorders ♦ A1c lab tests for persons with diabetes ♦ LDL lab tests for person with heart disease	**$0**

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Services that are covered for you	What you must pay when you get these services
• Blood—including storage and administration.	**$0**
• X-rays. • Electrocardiograms (EKGs), holter monitoring, and electroencephalograms (EEGs). • Ultrasounds. • Sleep studies.	**$0** per visit, per department
• Radiation (radium and isotope) therapy, including technician materials and supplies.	**$10** per visit
• Surgical supplies, such as dressings. • Splints, casts, and other devices used to reduce fractures and dislocations.	**$0** for surgical supplies or casts **$0** for take-home dressings and supplies, splints, and other devices to reduce fractures and dislocations
• Other outpatient diagnostic tests: ♦ Magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET).	**$0 per department visit**
♦ Any diagnostic test or special procedure that is provided in an outpatient department of a hospital or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.	**$25** per procedure
Outpatient hospital observation† Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.	**$50** per stay when admitted directly to the hospital for observation as an outpatient **Note:** There's no additional charge for outpatient observation stays when transferred for observation from an Emergency Department or following outpatient surgery.

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Services that are covered for you	What you must pay when you get these services
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	
Outpatient hospital services† We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an Emergency Department or outpatient clinic, such as observation services or outpatient surgery.	**Emergency Department** **$50** per visit **Outpatient surgery** **$25** per procedure Refer to the "Outpatient hospital observation" section of this Medical Benefits Chart for the cost-sharing applicable to observation services.
• Laboratory and diagnostic tests billed by the hospital. • X-rays and other radiology services billed by the hospital.	**Lab tests** • **$0 per department visit** **X-rays, ultrasounds, EKG, EEG, sleep studies, and holter monitoring** • **$0** per visit, per department **Radiation therapy** • **$10** per visit **MRI, CT, and PET** • **$0 per department visit**
• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it.	**$10** per day

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* Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
• Medical supplies such as splints and casts.	**$0** for surgical supplies or casts **$0** for splints or take home dressings and supplies
• Certain drugs and biologicals that you can't give yourself.	**$0**
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	
Outpatient mental health care† Covered services include: • Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	• **$10** per individual therapy visit • **$5** per group therapy visit
Outpatient rehabilitation services† Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**$10** per visit (or per day in a CORF)
Outpatient substance abuse services† Covered services include: • Intensive outpatient treatment program.	• **$10** per individual therapy visit • **$5** per group therapy visit
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers†	**$25** per procedure

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Services that are covered for you	What you must pay when you get these services
Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	
Outside service area benefit If you travel outside our service area, but inside the United States or its territories, we cover preventive, routine, follow-up, or continuing care office visits obtained from out-of-network Medicare providers not to exceed **$1,000** in covered Plan Charges per calendar year. We will pay up to 80% of the Medicare allowable charge, if the provider accepts assignment. Otherwise, we will pay 80% of the Medicare limiting charge, if the provider does not accept assignment.	**20%** of the Medicare allowable or limiting charges, and any amounts that exceed **$1,000** in Plan Charges per calendar year
Partial hospitalization services† "Partial hospitalization" is a structured program of active psychiatric treatment, provided as a hospital outpatient service or by a community mental health center that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.	**$10** per day
Physician/practitioner services, including doctor's office visits Covered services include: • †Medically necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location. • †Consultation, diagnosis, and treatment by a specialist. • Basic hearing and balance exams performed by a network provider, if your doctor orders it to see if you need medical treatment.	**Note:** Cost-sharing is charged based on the medical department where the service is provided, not the type of provider. In addition, multiple copayments may apply, depending on services provided and whether a consultation occurs. **Primary care office visits** • **$10** per visit

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Services that are covered for you	What you must pay when you get these services
• †Second opinion by another network provider prior to surgery. • †Nonroutine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician).	**Specialist office visits** • **$20** per visit **Outpatient hospital department or surgical center** You pay the following per procedure when it is provided in an outpatient or ambulatory surgery center, or in a hospital operating room, or in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort: • **$25**
• Chemotherapy visits.	**$10** per visit
• †Ultraviolet light treatments.	**$5** per visit
• †Visits for injections administered in outpatient settings.	**$0** per injection
• Certain telehealth services, including: primary and specialty care, which includes cardiac rehabilitation, physical therapy, speech therapy, mental health care, podiatry, substance abuse treatment, dialysis services, diabetes self-management training, preparation for surgery or a hospital stay, and follow up visits after a hospital stay, surgery, or Emergency Department visit. Services will only be provided by telehealth when deemed clinically appropriate by the network provider rendering the service. ♦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. We offer the following means of telehealth: o Interactive video visits for professional services when care can be provided in this format as determined by a network provider. o Scheduled telephone appointment visits for professional services when care can be provided in this format as determined by a network provider.	**$0**

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Services that are covered for you	What you must pay when you get these 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 receiving 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 to 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.	
Podiatry services† Covered services include:	**Specialist office visits** • **$20** per visit

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* Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	**Outpatient hospital department or surgical center** You pay the following per procedure when it is provided in an outpatient or ambulatory surgery center, or in a hospital operating room, or in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort: • **$25**
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	There is no coinsurance, copayment, or deductible for an annual digital rectal exam or PSA test.
Prosthetic devices and related supplies† Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery (see "Vision care" later in this section for more detail). Includes wigs following chemotherapy or radiation therapy (up to one synthetic wig per year).	**$0** for external prosthetic or orthotic devices and supplies (including wound care supplies) **$0** for surgically implanted internal devices and enteral and parenteral nutrition therapy
Pulmonary rehabilitation services† Comprehensive programs for pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**$10** per visit
Residential substance use disorder and mental health treatment†	**$25 per day up to $125 per admission**

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Services that are covered for you	What you must pay when you get these services
We cover the following services when the services are provided in a licensed residential treatment facility that provides 24-hour individualized substance use disorder or mental health treatment, the services are generally and customarily provided by a substance use disorder or mental health residential treatment program in a licensed residential treatment facility, and the services are above the level of custodial care: • Individual and group counseling. • Medical services. • Medication monitoring. • Room and board. • Drugs prescribed by a network provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel. • Discharge planning. There is no limit to the number of medically necessary days in our residential treatment program to treat mental health conditions and substance abuse when prescribed by a network provider.	Cost-sharing is charged per admission to a residential treatment program.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low-dose computed tomography (LDCT)† For qualified individuals, a LDCT is covered every 12 months. • Eligible members are people aged 50–77 years who have no signs or symptoms of lung cancer, but who have a	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

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Services that are covered for you	What you must pay when you get these services
history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. • For LDCT lung cancer screenings after the initial LDCT screening, the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20- to 30-minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care.	**$0**
• †Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as	**$0**

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

Services that are covered for you	What you must pay when you get these services
explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible).	
• †Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments). • †Home dialysis equipment and supplies. • †Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply).	**$0**
• †Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care).	No additional charge for services received during a hospital stay. Refer to the "Inpatient hospital care" section of this Medical Benefits Chart for the cost-sharing applicable to inpatient stays.
Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B drugs, please go to the section called "Medicare Part B prescription drugs."	
Skilled nursing facility (SNF) care† (For a definition of "skilled nursing facility care," see Chapter 12 of this document. Skilled nursing facilities are sometimes called "SNFs.") We cover **up to 100 days per benefit period of** skilled inpatient services in a skilled nursing facility in accord with Medicare guidelines (a prior hospital stay is not required). Covered services include, but are not limited to: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Skilled nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood—including storage and administration. • Medical and surgical supplies ordinarily provided by SNFs.	**$0**

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

Services that are covered for you	What you must pay when you get these services
• Laboratory tests ordinarily provided by SNFs. • X-rays and other radiology services ordinarily provided by SNFs. • Use of appliances such as wheelchairs ordinarily provided by SNFs. • Physician/practitioner services. Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital.	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) **If you use tobacco, but do not have signs or symptoms of tobacco-related disease:** We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. **If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:** We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Supervised Exercise Therapy (SET)† SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.	**$10** per visit

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

Services that are covered for you	What you must pay when you get these services
The SET program must: • Consist of sessions lasting 30–60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication. • Be conducted in a hospital outpatient setting or a physician's office. • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD. • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques. **Note:** SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time, if deemed medically necessary by a health care provider.	
Urgently needed services Urgently needed services are provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of our plan. Services must be immediately needed and medically necessary. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. • **Inside our service area:** You must obtain urgent care from network providers, unless our provider network is temporarily unavailable or inaccessible due to an unusual and extraordinary circumstance (for example, major disaster). • **Outside our service area:** You have worldwide urgent care coverage when you travel if you need medical attention right away for an unforeseen illness or injury and	**Office visits** **$30** per visit **Emergency Department visits** **$50** per visit

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

Services that are covered for you	What you must pay when you get these services
you reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our service area.	
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration.	**$20** per visit
• Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. However, our plan does cover the following exams: ♦ Routine eye exams (eye refraction exams) to determine the need for vision correction and to provide a prescription for eyeglass lenses. • Visual field tests.	**$10** per visit
• For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older, and Hispanic Americans who are 65 or older. • For people with diabetes, screening for and monitoring of diabetic retinopathy.	**$0**
• One pair of eyeglasses or one conventional contact lens or up to a six-month supply of disposable lenses (including fitting and dispensing) after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you can reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	**$0** for eyewear in accord with Medicare guidelines ***Note:** If the eyewear you purchase costs more than what Medicare covers, you pay the difference.
• *Prescription eyewear (eyeglass lenses, eyeglass frames, and contact lenses).	**Balance after $150 allowance to use toward the purchase price of eyewear**

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

Services that are covered for you	What you must pay when you get these services
	once within a two-calendar-year period. (If covered, see the Prescription Eyewear Rider in the **EOC** for additional information.)
"Welcome to Medicare" preventive visit We cover the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.
Note: Refer to Chapter 1 (Section 6) and Chapter 11 (Section 9) for information about coordination of benefits that applies to all covered services described in this Medical Benefits Chart.	

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

January 1 – December 31, 2023

Evidence of Coverage

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

This document gives you the details about your Medicare health care and prescription drug coverage from January 1 to December 31, 2023. This is an important legal document. Please keep it in a safe place.

For questions about this document, please contact Member Services at **1-877-221-8221** for additional information. (TTY users should call **711**.) Hours are 8 a.m. to 8 p.m., 7 days a week.

This plan, Kaiser Permanente Senior Advantage, is offered by Kaiser Foundation Health Plan of the Northwest (Health Plan). When this **Evidence of Coverage** says "we," "us," or "our," it means Health Plan. When it says "plan" or "our plan," it means Kaiser Permanente Senior Advantage (Senior Advantage).

This document is available in large print if you need it by calling Member Services (phone numbers are printed on the back cover of this document).

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2024. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

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

- Your plan premium and 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; and,
- Other protections required by Medicare law.

2023 Evidence of Coverage

Table of Contents

Chapter 1 — Getting started as a member

Section 1 — Introduction

Section 1.1 – You are enrolled in Senior Advantage, which is a Medicare HMO Plan

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Kaiser Permanente Senior Advantage.

We are required to cover all Part A and Part B services. However, cost-sharing and provider access in this plan differ from Original Medicare.

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

Coverage under this plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at **www.irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information.

Section 1.2 – What is the Evidence of Coverage document about?

This **Evidence of Coverage (EOC)** document tells you how to get your medical care and prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of our plan, and how to file a complaint if you are not satisfied with a decision or treatment.

If you are not certain which plan you are enrolled in, please call Member Services or your group's benefits administrator.

The words "coverage" and "covered services" refer to the medical care and services and the prescription drugs available to you as a member of our plan.

It's important for you to learn what our plan's rules are and what services are available to you. We encourage you to set aside some time to look through this **Evidence of Coverage** document.

If you are confused, concerned, or just have a question, please contact Member Services.

Section 1.3 – Term of the Evidence of Coverage

This **Evidence of Coverage** explains what our plan covers, in addition to your enrollment form, our **2023 Comprehensive Formulary,** and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

If your group renews on January 1, the **Evidence of Coverage** is in effect for the months in which you are enrolled in Senior Advantage between January 1, 2023, and December 31, 2023, unless amended.

If your group's **Agreement** renews at a later date in 2023, the term of this **Evidence of Coverage** is during that contract period, unless amended.

Your group can tell you the term of this **Evidence of Coverage** and whether this **Evidence of Coverage** is still in effect, and give you a current one if this **Evidence of Coverage** has been amended.

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

Section 2 — What makes you eligible to be a plan member?

Section 2.1 – Your Senior Advantage eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B.
- You live in our geographic service area (Section 2.4 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- You are a United States citizen or are lawfully present in the United States.

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).

Section 2.2 – Group eligibility requirements

In addition to the Senior Advantage eligibility requirements in this section, you must meet the following requirements to be eligible to enroll and to remain enrolled under your group's plan:

- You must meet your group's eligibility requirements that we have approved. (Your group is required to inform subscribers of its eligibility requirements.)
- You must meet the subscriber and dependent eligibility requirements described below unless your group has different eligibility requirements that we have approved.

You may be eligible to enroll as a subscriber under this **Evidence of Coverage** if you are:

- An employee of your group, or
- Otherwise entitled to coverage through your group under a trust agreement, retirement benefit program, rules of a professional, trade, or bona fide association, or employment contract (unless the Internal Revenue Service considers you self-employed).

If you are a subscriber enrolled under this **Evidence of Coverage** or a subscriber enrolled in a non-Medicare plan offered by your group, the following persons may be eligible to enroll as your

dependents under this **Evidence of Coverage** if they meet all the other requirements described under this Section 2:

- Your spouse.
- A person who is under the dependent limiting age specified by your group and who is any of the following (check with your group to determine the age limit for dependents):
  - Your or your spouse's child.
  - A child adopted by you or your spouse, or for whom you or your spouse have assumed a legal obligation in anticipation of adoption.
  - Any other person for whom you or your spouse is a court-appointed guardian.
- A person of any age who is chiefly dependent upon you or your spouse for support and maintenance if the person is incapable of self-sustaining employment by reason of developmental disability or physical handicap which occurred prior to his or her reaching the dependent limiting age specified by your group, if the person is any of the following:
  - Your or your spouse's child.
  - A child adopted by you or your spouse, or for whom you or your spouse have assumed a legal obligation for total or partial support in anticipation of adoption.
  - Any other person for whom you or your spouse is a court-appointed guardian and was a court-appointed guardian prior to the person's reaching the dependent limiting age specified by your group.

We may request proof of incapacity and dependency annually.

Note: Children born to an eligible dependent other than your spouse are not eligible for coverage beyond the first 31 days of life, including the date of birth, unless:

- You or your spouse adopts them or assumes a legal obligation in anticipation of adoption, or
- They are primarily supported by you or your spouse and you or your spouse is their court-appointed guardian.

Note: If you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this **Evidence of Coverage**, 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.

Section 2.3 – When you can enroll and when coverage begins

Your group is required to inform you when you are eligible to enroll and your effective date of coverage under this **Evidence of Coverage**. If you are eligible to enroll as described in this Section 2, enrollment is permitted and membership begins at the beginning (12:00 a.m.) of the effective date of coverage, except that:

- Your group may have additional requirements that we have approved, which allow enrollment in other situations.

- The effective date of your Senior Advantage coverage under this **Evidence of Coverage** must be confirmed by the Centers for Medicare & Medicaid Services (CMS), as described in this Section 2.3.

If you are eligible to be a dependent under this **Evidence of Coverage** 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 Section 2.3.

New subscribers

When your group informs you that you are eligible to enroll as a subscriber, you may enroll yourself and any eligible dependents by submitting the applicable Health Plan-approved enrollment application or Senior Advantage Election Form for each person, to your group within 31 days.

After we receive your completed Senior Advantage Election Form, we will submit your enrollment request to CMS for confirmation and send you a notice indicating the proposed effective date of your Senior Advantage coverage under this **Evidence of Coverage**.

If CMS confirms your Senior Advantage enrollment and effective date, we will send you a notice that confirms your enrollment and effective date. If CMS tells us that you do not have Medicare Part B coverage, we will notify you that you will be disenrolled from Senior Advantage.

Adding new dependents to an existing account

To enroll a dependent who first becomes eligible to enroll after you became a subscriber (such as a new spouse, a newborn child, or a newly adopted child), you must submit the applicable Health Plan–approved change of enrollment form or a Senior Advantage Election Form to your group within 31 days after the dependent first becomes eligible. The effective date of coverage for newly acquired dependents is determined by your group, subject to confirmation by CMS.

Group open enrollment

Your group will let you know when their open enrollment period begins and ends. You may enroll as a subscriber along with any eligible dependents, and existing subscribers may add eligible dependents not previously enrolled, by submitting a Health Plan-approved enrollment application and/or a Senior Advantage Election Form for each person to your group. Your group will let you know the effective date of coverage, subject to confirmation by CMS.

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 you experience a qualifying event as defined in applicable federal law. Examples of qualifying events include, but are not limited to:

- Gaining a dependent through marriage, birth, adoption or placement for adoption.
- Loss of a dependent through divorce or legal separation, or if the enrollee or his or her dependent dies.

Note: If you are enrolling as a subscriber along with at least one eligible dependent, only one of you must meet one of the requirements for a qualifying event.

You must notify your group within 30 days of a qualifying event, 60 days if you are requesting enrollment due to a change in eligibility for Medicaid or Child Health Insurance Program (CHIP) coverage. Your group will determine if you are eligible to select or change coverage. Contact your group for further instructions on how to enroll.

Note: If you previously declined coverage, your group may have required you to provide a written statement indicating whether the coverage was being declined due to other health coverage. If this statement is not provided, or if coverage was not declined due to other health coverage, you may not be eligible for special enrollment due to loss of other health coverage. Contact your group for further information.

Section 2.4 – Here is our plan service area for Senior Advantage

Our plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in **Oregon**: **Clackamas, Columbia, Hood River, Lane, Marion, Multnomah, Polk, Washington,** and **Yamhill**. Also, our service area includes these parts of counties in Oregon, **in the following ZIP codes only**:

- **Benton:** 97321, 97330, 97331, 97333, 97339, 97370.
- **Linn:** 97321, 97322, 97335, 97355, 97358, 97360, 97374, 97383, 97389.

Our service area includes **Clark, Cowlitz,** and **Skamania** counties in **Washington**. Also, our service area includes parts of **Wahkiakum County** in **Washington, in the following ZIP codes only**: 98612, 98647.

If you plan to move out of the service area, you cannot remain a member of this plan.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.5 – U.S. citizen or lawful presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (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.

Section 3 — Important membership materials you will receive

Section 3.1 – Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. You

should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:

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

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Section 3.2 – Provider Directory

The **Provider Directory** lists our network providers and durable medical equipment suppliers.

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full.

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

The most recent list of providers and suppliers is available on our website at **kp.org/directory**. If you don't have your copy of the **Provider Directory**, you can request a copy from Member Services.

Section 3.3 – Pharmacy Directory

The **Pharmacy Directory** lists our network pharmacies. Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the **Pharmacy Directory** to find the network pharmacy you want to use. See Chapter 5, Section 2.5, for information on when you can use pharmacies that are not in the plan's network.

If you don't have the **Pharmacy Directory**, you can get a copy from Member Services. You can also find this information on our website at **kp.org/directory**.

Section 3.4 – Our plan's list of covered drugs (formulary)

Our plan has a **2023 Comprehensive Formulary**. We call it the "Drug List" for short. It tells you which Part D prescription drugs are covered under the Part D benefit included in our plan. The drugs on this list are selected by our plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved our Drug List. The Drug List also tells you if there are any rules that restrict coverage for your drugs. We will provide you a copy of our Drug List. To get the most complete and current information about which drugs are covered, you can visit our website **(kp.org/seniorrx)** or call Member Services.

Section 4 — Costs

Your costs may include the following:

- Plan premium (Section 4.1).
- Monthly Medicare Part B premium (Section 4.2).
- Part D late enrollment penalty (Section 4.3).
- Income Related Monthly Adjusted Amount (Section 4.4).

Section 4.1 – Plan premium

Your coverage is provided through a group contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your plan premium.

Section 4.2 – Monthly Medicare Part B premium

Many members are required to pay other Medicare premiums

You must continue paying your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

Section 4.3 – Part D late enrollment penalty

Some members are required to pay a Part D late enrollment penalty. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage. The Part D late enrollment penalty will be applied to the overall premium your group pays us. Your group will inform you if you are required to reimburse the Part D late enrollment penalty amount to the group.

You will not have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information because you may need it if you join a Medicare drug plan later.
  - **Note**: Any notice must state that you had "creditable" prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
  - **Note:** The following are not creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is 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, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2023, this average premium amount is $32.74.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times $32.74, which equals $4.58. This rounds to $4.60. This amount would be added to the monthly premium for someone with a Part D late enrollment penalty.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year** because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, 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 that 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 request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. However, if you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty.

Section 4.4 – Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from two 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/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans**.

If you have to pay an extra amount, Social Security, not our 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, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **If you do not pay the extra amount, you will be disenrolled from the plan and lose prescription drug coverage.**

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

Section 5 — Keeping your plan membership record up-to-date

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

The doctors, hospitals, pharmacists, and other providers in our network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost-sharing amounts for you.** Because of this, it is very important that you help us keep your information up-to-date.

Let us know about these changes:

- Changes to your name, your address, or your phone number.
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid).
- If you have any liability claims, such as claims from an automobile accident.
- If you have been admitted to a nursing home.
- If you receive care in an out-of-area or out-of-network hospital or emergency room.
- If your designated responsible party (such as a caregiver) changes.
- If you are participating in a clinical research study. (**Note**: You are not required to tell your plan about the clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, please let us know by calling Member Services.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 6 — How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called "**Coordination of Benefits**."

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends upon your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
  - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
  - If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees. (If you are over 65 and a domestic partner, different rules apply.)
  - If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

Chapter 2 — Important phone numbers and resources

Section 1 — Kaiser Permanente Senior Advantage contacts (how to contact us, including how to reach Member Services)

How to contact our plan's Member Services

For assistance with claims, billing, or membership card questions, please call or write to Senior Advantage Member Services. We will be happy to help you.

METHOD	Member Services – contact information
CALL	**1-877-221-8221** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Kaiser Permanente Member Services 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099
WEBSITE	**kp.org**

How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)."

METHOD	Coverage decisions about medical care – contact information
CALL	**1-877-221-8221** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.

METHOD	Coverage decisions about medical care – contact information
WRITE	Member Relations/Coverage Decisions Kaiser Permanente 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099
WEBSITE	**https://healthy.kaiserpermanente.org/oregon-washington/support**

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. For more information about asking for coverage decisions about your Part D prescription drugs, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)."

METHOD	Coverage decisions for Part D prescription drugs – contact information
CALL	**1-888-791-7245** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
FAX	**1-844-403-1028**
WRITE	OptumRx c/o Prior Authorization P.O. Box 25183 Santa Ana, CA 92799
WEBSITE	**kp.org**

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

An appeal is a formal way of asking us to review and change a coverage decision we have made. You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes.

For more information about making an appeal or a complaint about your medical care or your Part D prescription drugs, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)."

METHOD	Appeals or complaints about medical care or Part D prescription drugs – contact information
CALL	**1-877-221-8221** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
FAX	**1-855-347-7239**
WRITE	Kaiser Permanente Member Relations 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099
WEBSITE	**kp.org**
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to **www.medicare.gov/MedicareComplaintForm/home.aspx.**

Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 7, "Asking us to pay our share of a bill you have received for covered medical services or drugs."

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," for more information.

METHOD	Payment requests – contact information
CALL	**1-877-221-8221** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Kaiser Permanente Claims Department Northwest Region P.O. Box 370050 Denver, CO 80237-9998
WEBSITE	**kp.org**

Section 2 — Medicare (how to get help and information directly from the federal Medicare program)

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

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

METHOD	Medicare – contact information
CALL	**1-800-MEDICARE** or **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 with hearing or speaking. Calls to this number are free.
WEBSITE	**www.medicare.gov** This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options, with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about our plan: • **Tell Medicare about your complaint:** You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to **www.medicare.gov/MedicareComplaintForm/home.aspx.** Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

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

Section 3 — State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

Here is a list of the State Health Insurance Assistance Programs in each state we serve:

- In Oregon, the SHIP is called Senior Health Insurance Benefits Assistance (SHIBA).
- In Washington, the SHIP is called Statewide Health Insurance Benefits Advisors (SHIBA).

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

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

Method to access SHIP and other resources:

- Visit **www.medicare.gov.**
- Click on **"Talk to Someone"** in the middle of the home page.
- You now have the following options:
  - Option 1: You can have a live chat with a **1-800-MEDICARE** representative.
  - Option 2: You can select your state from the dropdown menu and click "Go." This will take you to a page with phone numbers and resources specific to your state.

METHOD	Senior Health Insurance Benefits Assistance (Oregon's SHIP) – contact information	Statewide Health Insurance Benefits Advisors (Washington's SHIP) – contact information
CALL	**1-800-722-4134**	**1-800-562-6900**
TTY	**711**	**1-360-586-0241** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Oregon SHIBA P.O. Box 14480 Salem, OR 97309	Washington SHIBA P.O. Box 40255 Olympia, WA 98504-0255
WEBSITE	**shiba.oregon.gov**	**insurance.wa.gov/shiba**

Section 4 — Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Oregon and Washington, the Quality Improvement Organization is called KEPRO.

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

You should contact KEPRO in any of these situations:

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

METHOD	KEPRO (Oregon's and Washington's Quality Improvement Organization) – contact information
CALL	**1-888-305-6759** Calls to this number are free. Monday through Friday, 9 a.m. to 5 p.m. Weekends and holidays, 11 a.m. to 3 p.m.
TTY	**711**

METHOD	KEPRO (Oregon's and Washington's Quality Improvement Organization) – contact information
WRITE	KEPRO 5201 West Kennedy Blvd., Suite 900 Tampa, FL 33609
WEBSITE	**www.keproqio.com**

Section 5 — Social Security

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

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

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

METHOD	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. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	**1-800-325-0778** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 a.m. to 7 p.m., Monday through Friday.
WEBSITE	**www.ssa.gov**

Section 6 — Medicaid

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

The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" include:

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

To find out more about Medicaid and its programs, contact Oregon's or Washington's Medicaid program.

METHOD	Oregon Health Plan – contact information	Washington State Department of Social and Health Services – contact information
CALL	**1-800-273-0557** Monday–Friday, 8 a.m.–5 p.m.	**1-877-501-2233** Monday–Friday, 8 a.m.–5 p.m.
TTY	**711**	**711**
WRITE	Division of Medical Assistance Programs 500 Summer St. NE Salem, OR 97301	Department of Social and Health Services 1115 Washington St. SE Olympia, WA 98504
WEBSITE	**healthcare.oregon.gov**	**washingtonconnection.org**

Section 7 — Information about programs to help people pay for their prescription drugs

The Medicare.gov website (**https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs**) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This "Extra Help" also counts toward your out-of-pocket costs.

If you automatically qualify for "Extra Help," Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify, you may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, 24 hours a day/7 days a week;
- The Social Security Office at **1-800-772-1213**, between 8 a.m. to 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778** (applications); or
- Your state Medicaid office (applications) (see Section 6 in this chapter for contact information).

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either to request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

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

You or your appointed representative may need to provide the evidence to a network pharmacy when obtaining covered Part D prescriptions so that we may charge you the appropriate cost-sharing amount until the Centers for Medicare & Medicaid Services (CMS) updates its records to reflect your current status. Once CMS updates its records, you will no longer need to present the evidence to the pharmacy. Please 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 232407
  San Diego, CA 92193-2407
- Fax it to **1-877-528-8579**.
- Take it to a network pharmacy or your local Member Services office at a network facility.

When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment, or we will offset future copayments. If the pharmacy hasn't

collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make the payment directly to the state. Please contact Member Services if you have questions.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)? What is the AIDS Drug Assistance Program (ADAP)?
The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance through the CAREAssist program in Oregon and the Early Intervention Program in Washington.

Note: To be eligible for the ADAP operating in your state, individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/underinsured status. If you change plans, please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, Oregon residents, please call **1-800-805-2313**, and Washington residents, please call **1-877-376-9316**.

Section 8 — How to contact the Railroad Retirement Board

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

METHOD	Railroad Retirement Board – contact information
CALL	**1-877-772-5772** Calls to this number are free. If you press "0," you may speak with an RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9 a.m. to 12 p.m. on Wednesday. If you press "1," you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	**1-312-751-4701** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are not free.
WEBSITE	**rrb.gov/**

Section 9 — Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. Phone numbers for Member Services are printed on the back cover of this document. You may also call **1-800-MEDICARE** (**1-800-633-4227**; TTY: **1-877-486-2048**) with questions related to your Medicare coverage under this plan.

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.

Chapter 3 — Using our plan for your medical services

Section 1 — Things to know about getting your medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered. It gives you definitions of terms and explains the rules you will need to follow to get the medical treatments, services, equipment, prescription drugs, and other medical care that are covered by our plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart found at the front of this **EOC**.

Section 1.1 – What are "network providers" and "covered services"?

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

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

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

We will generally cover your medical care as long as:

- **The care you receive is included in our plan's Medical Benefits Chart** (found at the front of this **EOC**).
- **The care you receive is considered medically necessary.** "Medically necessary" means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider** (a PCP) who is providing and overseeing your care. As a member of our plan, we encourage you to choose a network PCP (for more information about this, see Section 2.1 in this chapter).
  - In most situations, your network PCP must give you a referral in advance before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing

facilities, or home health care agencies. This is called giving you a "referral" (for more information about this, see Section 2.3 in this chapter).

- Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 in this chapter).

- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. Here are five exceptions:
  - We cover emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost-sharing you normally pay in-network if we or our Medical Group authorize the services before you get the care. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
  - We cover kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost-sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside our plan's network, the cost-sharing for the dialysis may be higher.
  - If you travel outside our service area, but inside the United States or its territories, we will provide limited coverage for preventive, routine, follow-up, and continuing care obtained from out-of-network providers (see the Medical Benefits Chart found at the front of this **EOC** for more information).
  - Care you receive from network providers in other Kaiser Permanente regions described in Section 2.4 in this chapter.

Section 2 — Use providers in our network to get your medical care

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

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

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

Your PCP provides, prescribes, or authorizes medically necessary covered services. Your PCP will provide most of your routine or basic care and provide a referral as needed to see other network providers for other care you need. For example, to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist). There are a few types of covered services you can get on your own without contacting your PCP first (see Section 2.2 in this chapter).

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

How do you choose or change your PCP?

You may change your PCP for any reason and at any time from our available PCPs, including if you need to select a new PCP because your PCP isn't part of our network of providers any longer. Your PCP selections will be effective immediately.

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

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

Section 2.2 – What kinds of medical care can you get without a referral from your PCP?

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

- Routine women's health care, which includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider.
- Flu shots, COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.

- Emergency services from network providers or from out-of-network providers.
- Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.)
- Second opinions from another network provider except for certain specialty care.
- Medicare-covered preventive care as specified in the Medical Benefits Chart found at the front of this **EOC**.
- Outpatient care for mental health at network Mental Health Departments.
- Routine vision exams.
- Routine hearing exams.
- Cancer counseling.

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

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

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

Referrals from your PCP

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

Referrals to network providers

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

Prior authorization

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

- Services and items identified in the Medical Benefits Chart found at the front of this **EOC** with a footnote (†).
- If your network provider decides that you require covered services not available from network providers, he or she will recommend to Medical Group that you be referred to an out-of-network provider inside or outside our service area. The appropriate Medical Group designee will authorize the services if he or she determines that the covered services are medically necessary and are not available from a network provider. Referrals to out-of-network providers will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. It specifies the duration of the referral without having to get additional approval from us. Please ask your network provider what services have been authorized if you are not certain. If the out-of-network specialist wants you to come back for more care, be sure to check if the referral covers the additional care. If it doesn't, please contact your network provider.
- After we are notified that you need post-stabilization care from an out-of-network provider following emergency care, we will discuss your condition with the out-of-network provider. If we decide that you require post-stabilization care and that this care would be covered if you received it from a network provider, we will authorize your care from the out-of-network provider only if we cannot arrange to have a network provider (or other designated provider) provide the care. Please see Section 3.1 in this chapter for more information.
- Medically necessary transgender surgery and associated procedures.
- Medically necessary bariatric surgery.
- Care from a religious nonmedical health care institution described in Section 6 of this chapter.
- If your network provider makes a written or electronic referral for a transplant, Medical Group's regional transplant advisory committee or board (if one exists) will authorize the services if it determines that they are medically necessary or covered in accord with Medicare guidelines. In cases where no transplant committee or board exists, Medical Group will refer you to physician(s) at a transplant center, and Medical Group will authorize the services if the transplant center's physician(s) determine that they are medically necessary or covered in accord with Medicare guidelines.

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure that the medically necessary treatment you are receiving is not interrupted.
- If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost-sharing. The appropriate Medical Group designee will authorize the services if he or she determines that the covered services are medically necessary and are not available from a network provider. Referrals to out-of-network providers will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. It specifies the duration of the referral without having to get additional approval from us. Please ask your network provider what services have been authorized if you are not certain. If the out-of-network specialist wants you to come back for more care, be sure to check if the referral covers the additional care. If it doesn't, please contact your network provider.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to our plan, or both. Please see Chapter 9.

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

Care you receive from an out-of-network provider will not be covered except in the following situations:

- Emergency or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services mean, see Section 3 in this chapter.
- We or Medical Group authorize a referral to an out-of-network provider described in Section 2.3 of this chapter.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area.
- If you visit the service area of another Kaiser Permanente region, you can receive certain care covered under this **Evidence of Coverage** from designated providers in that service area.

Please call our care away from home travel line at **1-951-268-3900** (TTY **711**), 24 hours a day, 7 days a week (except holidays), or visit our website at **kp.org/travel** for more information about getting care when visiting another Kaiser Permanente Region's service area, including coverage information and facility locations. Kaiser Permanente is located in California, District of Columbia, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. **Note:** Our care away from home travel line can also answer questions about covered emergency or urgent care services you receive out-of-network, including how to get reimbursement.

- If you travel outside our service area, but inside the United States or its territories, we will provide coverage for preventive, routine, follow-up, and continuing care obtained from out-of-network providers not to exceed the annual benefit maximum (see the Medical Benefits Chart found at the front of this **EOC** for more information).

Section 3 — How to get services when you have an emergency or urgent need for care or during a disaster

Section 3.1 – Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere inside or outside the United States.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The number to call is listed on the back of your plan membership card.

What is covered if you have a medical emergency?

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

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

We will partner with the doctors who are providing the emergency care to help manage and follow up on your care. After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors

contact us and make plans for additional care. We will cover your follow-up post-stabilization care in accord with Medicare guidelines. It is very important that your provider call us to get authorization for post-stabilization care before you receive the care from the out-of-network provider. In most cases, you will only be held financially liable if you are notified by the out-of-network provider or us about your potential liability.

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

What if it wasn't a medical emergency?

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

However, after the doctor has said that it was not an emergency, we will cover additional care only if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- Or the additional care you get is considered "urgently needed services" and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

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

What are "urgently needed services"?

An urgently needed service is a non-emergency situation requiring immediate medical care but given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

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

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

- You are temporarily outside of our service area.

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

Section 3.3 – Getting care during a disaster

If the governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from us.

Please visit our website **kp.org** for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, our plan will allow you to obtain care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5, for more information.

Section 4 — What if you are billed directly for the full cost of your services?

Section 4.1 – You can ask us to pay our share of the cost for covered services

If you have paid more than your plan cost-sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7, "Asking us to pay our share of a bill you have received for covered medical services or drugs," for information about what to do.

Section 4.2 – If services are not covered by our plan, you must pay the full cost

We cover all medically necessary services as listed in the Medical Benefits Chart found at the front of this **EOC**. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

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

Section 5 — How are your medical services covered when you are in a "clinical research study"?

Section 5.1 – What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study, and you have a full understanding and acceptance of what is involved if you participate in the study.

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 that you are in a qualified clinical trial, then you are 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 will reimburse the difference between what you paid and the in-network cost-sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in any Medicare-approved clinical research study, you do not need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do not need to be part of our plan's network of providers.

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

If you participate in a study that Medicare has not approved, you will be responsible for paying all costs for your participation in the study.

Section 5.2 – When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you receive 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 is part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare has paid 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 will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 7 for more information for submitting requests for payments.

Here's an example of how the cost-sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan.

The plan would then directly pay you $10. Therefore, your net payment is $10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

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

- Generally, Medicare will not pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were not in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication "Medicare and Clinical Research Studies." (The publication is available at **www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf**.) You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Section 6 — Rules for getting care in a "religious nonmedical health care institution"

Section 6.1 – What is a religious nonmedical health care institution?

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

Section 6.2 – Receiving care from a religious nonmedical health care institution

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to nonreligious aspects of care.

- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - – and – you must get approval in advance from our plan before you are admitted to the facility, or your stay will not be covered.

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

Section 7 — Rules for ownership of durable medical equipment

Section 7.1 – Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech-generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

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

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

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.

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

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2 — Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

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

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

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

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

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

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

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

The Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of our plan is found at the front of this **EOC**. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services. In addition, please see Chapter 3, Chapter 11, and Chapter 12 for additional coverage information, including limitations (for example, coordination of benefits, durable medical equipment, home health care, skilled nursing facility care, and third party liability).

Section 1.1 – Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service unless we do not collect all cost-sharing at that time and send you a bill later. (The Medical Benefits Chart found at the front of this **EOC** tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service unless we do not collect all cost-sharing at that time and send you a bill later. (The Medical Benefits Chart found at the front of this **EOC** tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments, or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

Section 1.2 – What is the most you will pay for Medicare Part A and Part B covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the total amount you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2023, this amount can be found in the Medical Benefits Chart at the front of this **EOC**.

The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk (*) in the Medical Benefits Chart. If you reach the maximum out-of-

pocket amount stated in the Medical Benefits Chart at the front of the **EOC**, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 – Our plan does not allow providers to "balance bill" you

As a member of our plan, an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called "balance billing." This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. Here is how this protection works:

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15), then you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends upon which type of provider you see:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, we cover services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for nonparticipating providers. (Remember, we cover services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
- If you believe a provider has "balance billed" you, call Member Services.

Section 2 — Use the Medical Benefits Chart at the front of this EOC to find out what is covered and how much you will pay

Section 2.1 – Your medical benefits and costs as a member of our plan

The Medical Benefits Chart found at the front of this **EOC** lists the services we cover and what you pay out-of-pocket for each service. Part D prescription drug coverage is in Chapter 5. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.

- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) must be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered, unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in our plan's network. This is called giving you a "referral."
- Some of the services listed in the Medical Benefits Chart found at the front of this **EOC** are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart with a footnote (†). In addition, see Chapter 3, Section 2.3, for more information about prior authorization, including other services that require prior authorization that are not listed in the Medical Benefits Chart.

Other important things to know about our coverage

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay more in our plan than you would in Original Medicare. For others, you pay less. (If you want to know more about the coverage and costs of Original Medicare, look in your **Medicare & You** 2023 handbook. View it online at **www.medicare.gov** or ask for a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, cost-sharing will apply for the care received for the existing medical condition.
  -  You will see this apple next to the preventive services in the Medical Benefits Chart found at the front of this **EOC**.
- If Medicare adds coverage for any new services during 2023, either Medicare or our plan will cover those services.

Section 3 — What services are not covered by our plan?

Section 3.1 – Services we do not cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and, therefore, are not covered by this plan.

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

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		Available for people with chronic low back pain under certain circumstances.
Care in an intermediate or residential care facility, assisted living facility, or adult foster home		Covered as described in "Residential substance use disorder and mental health treatment" section of the Medical Benefits Chart.
Conception by artificial means, such as in vitro fertilization, zygote intrafallopian transfers, ovum transplants, and gamete intrafallopian transfers (except artificial insemination and related services covered by Medicare)	√	
Cosmetic surgery or procedures		Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Custodial care • Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	√	
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance)		Covered if medically necessary and covered under Original Medicare.
Experimental medical and surgical procedures, equipment, and medications • Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		May be covered by Original Medicare under a Medicare-approved clinical research study. (See Chapter 3, Section 5, for more information about clinical research studies.)
Eyeglasses and contact lenses		One pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Fees charged by your immediate relatives or members of your household.	√	
Full-time nursing care in your home	√	
Hearing aids		This exclusion doesn't apply to cochlear implants and osseointegrated external hearing devices covered by Medicare.
Home-delivered meals		Covered in limited situations as described in the Medical Benefits Chart.
Homemaker services include basic household assistance, including light housekeeping or light meal preparation	√	
Licensed ambulance services without transport		Covered if the ambulance transports you or if covered by Medicare.
Massage therapy		Covered when ordered as part of physical therapy program in accord with Medicare guidelines.
Naturopath services (uses natural or alternative treatments)	√	
Nonconventional intraocular lenses (IOLs) following cataract surgery (for example, a presbyopia-correcting IOL)	√	
Nonroutine dental care		Dental care required to treat illness or injury may be covered as inpatient or outpatient care.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Orthopedic shoes or supportive devices for the feet		Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility such as a telephone or a television	√	
Physical exams and other services (1) required for obtaining or maintaining employment or participation in employee programs, (2) required for insurance or licensing, or (3) on court order or required for parole or probation		Covered if a network physician determines that the services are medically necessary or medically appropriate preventive care.
Private duty nursing	√	
Private room in a hospital		Covered when medically necessary.
Psychological testing for ability, aptitude, intelligence, or interest	√	
Radial keratotomy, LASIK surgery, and other low-vision aids	√	
Reconstructive surgery that offers only a minimal improvement in appearance or is performed to alter or reshape normal structures of the body in order to improve appearance		We cover reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defect, developmental abnormalities, accidental injury, trauma, infection, tumors, or disease, if a network physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Reversal of sterilization procedures and non-prescription contraceptive supplies	√	
Routine chiropractic care		Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings, fillings, or dentures	√	
Routine foot care		Some limited coverage provided according to Medicare guidelines (for example, if you have diabetes).
Services considered not reasonable and necessary, according to Original Medicare standards		This exclusion doesn't apply to services or items that aren't covered by Original Medicare but are covered by our plan.
Services provided to veterans in Veterans Affairs (VA) facilities		When emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our plan's cost-sharing amounts.
Services related to noncovered services or items		When a service or item is not covered, all services related to the noncovered service or item are excluded, (1) except for services or items we would otherwise cover to treat complications of the noncovered service or item, or (2) unless covered in accord with Medicare guidelines.
Services to reverse voluntary, surgically induced infertility	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a network provider	√	
Travel and lodging expenses/living expenses		We may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines for transplants. Your transplant coordinator can provide information about covered expenses.

Services and benefits under an individual Senior Advantage plan are excluded when a member is enrolled under an employer group Senior Advantage plan. Members enrolled in a Kaiser Foundation Health Plan of the Northwest employer group Senior Advantage plan cannot be enrolled in the individual Senior Advantage Enhanced, Standard, Standard Lane, Value or Value Lane plan at the same time.

Chapter 5 — Using our plan's coverage for Part D prescription drugs

Section 1 — Introduction

This chapter explains rules for using your coverage for Part D drugs. Please see the Medical Benefits Chart found at the front of this **EOC** for Medicare Part B drug benefits and hospice drug benefits.

Section 1.1 – Basic rules for our plan's Part D drug coverage

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's exclusion or preclusion lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2 in this chapter, "Fill your prescription at a network pharmacy or through our mail-order service.")
- Your drug must be on our **2023 Comprehensive Formulary** (we call it the "Drug List" for short). (See Section 3 in this chapter, "Your drugs need to be on our Drug List.")
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

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

Section 2.1 – Use a network pharmacy

In most cases, your prescriptions are covered only if they are filled at our network pharmacies. (See Section 2.5 in this chapter for information about when we would cover prescriptions filled at out-of-network pharmacies.)

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

Section 2.2 – Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your **Pharmacy Directory**, visit our website (**kp.org/directory**), and/or call Member Services.

You may go to any of our network pharmacies.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves our plan's network, you will have to find a new pharmacy that is in our network. To find another pharmacy in your area, you can get help from Member Services or use the **Pharmacy Directory**. You can also find information on our website at **kp.org/directory**.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network. I/T/U pharmacies must be within our service area.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. **Note: This scenario should happen rarely.**

To locate a specialized pharmacy, look in your **Pharmacy Directory** or call Member Services.

Section 2.3 – Using our mail-order services

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

Our plan's mail-order service allows you to order up to a 90-day supply.

To get information about filling your prescriptions by mail, visit your local Kaiser Permanente pharmacy or call **1-800-548-9809** (TTY **711**), Monday through Friday, 8 a.m. to 5:30 p.m. You can conveniently order your prescription refills in the following ways:

- Register and order online securely at **kp.org/refill**.
- Call the mail-order pharmacy toll free at **1-800-548-9809** (TTY **711**), Monday through Friday, 8 a.m. to 5:30 p.m.
- Mail your prescription or refill request on a mail order form available at any Kaiser Permanente pharmacy.

When you order refills for home delivery by phone or online, you must pay your cost-sharing when you place your order (there are no shipping charges for regular USPS mail delivery). If you prefer, you may designate a network pharmacy where you want to pick up and pay for your prescription. Please contact a network pharmacy if you have a question about whether your prescription can be mailed or see our Drug List for information about the drugs that can be mailed.

Usually, a mail-order pharmacy order will be delivered to you in no more than 5 days. If your mail-order prescription is delayed, please call our mail-order pharmacy for assistance at **1-800-548-9809** (TTY 711), Monday through Friday 8 a.m. to 5:30 p.m. Also, if you cannot wait for your prescription to arrive from our mail-order pharmacy, you can get an urgent supply by calling your local network retail pharmacy listed in your **Pharmacy Directory** or at **kp.org/directory**. Please be aware that you may pay more if you get a 90-day supply from a network retail pharmacy instead of from our mail-order pharmacy.

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

Section 2.4 – How can you get a long-term supply of drugs?

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

- Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your **Pharmacy Directory** tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.
- You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

Section 2.5 – When can you use a pharmacy that is not in our network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. Please check first with Member Services to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are traveling within the United States and its territories but outside the service area and you become ill or run out of your covered Part D prescription drugs, we 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 need a Medicare Part D prescription drug in conjunction with covered out-of-network emergency care or out-of-area urgent care, we will cover up to a 30-day supply from an out-of-network pharmacy. Note: Prescription drugs prescribed and provided outside of the United States and its territories as part of covered emergency or urgent care are covered up to a 30-day supply in a 30-day period. These drugs are not covered under Medicare Part D;

therefore, payments for these drugs do not count toward reaching the catastrophic coverage stage.

- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24-hour service. We may not cover your prescription if a reasonable person could have purchased the drug at a network pharmacy during normal business hours.
- If you are trying to fill a prescription for a drug that is not regularly stocked at an accessible network pharmacy or available through our mail-order pharmacy (including high-cost drugs).
- If you are not able to get your prescriptions from a network pharmacy during a disaster.

How do you ask for reimbursement from our plan?

If you must use an out-of-network pharmacy, you will 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. (Chapter 7, Section 2, explains how to ask us to pay you back.)

Section 3 — Your drugs need to be on our "Drug List"

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

Our plan has a **2023 Comprehensive Formulary**. In this **Evidence of Coverage**, we call it the "Drug List" for short.

The drugs on this list are selected by our plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The drugs on the Drug List are only those covered under Medicare Part D.

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

- Approved by the Food and Drug Administration 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 DRUGDEX Information System.

Our Drug List includes brand-name drugs, generic drugs, and biosimilars

A brand-name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand-name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. 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. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand-name drug or biological product and usually cost less. There are generic drug substitutes or biosimilar alternatives available for many brand-name drugs and some biological products.

What is not on our Drug List?

Our plan does not cover all prescription drugs.

In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).

In other cases, we have decided not to include a particular drug on our Drug List. In some cases, you may be able to obtain a drug that is not on the drug list. For more information, please see Chapter 9.

Section 3.2 – There are six "cost-sharing tiers" for drugs on our Drug List

Every drug on our plan's Drug List is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Cost-sharing **Tier 1** for preferred generic drugs (this tier includes some brand-name drugs).
- Cost-sharing **Tier 2** for generic drugs (this tier includes some brand-name drugs).
- Cost-sharing **Tier 3** for preferred brand-name drugs.
- Cost-sharing **Tier 4** for nonpreferred brand-name drugs (this tier includes some generic drugs).
- Cost-sharing **Tier 5** for specialty-tier drugs (this tier includes both generic and brand-name drugs).
- Cost-sharing **Tier 6** for injectable Part D vaccines (this tier includes only brand-name drugs).

To find out which cost-sharing tier your drug is in, look it up on our Drug List. The amount you pay for drugs is shown in the Medical Benefits Chart at the front of this **EOC**.

Section 3.3 – How can you find out if a specific drug is on our Drug List?

You have three ways to find out:

- Check the most recent Drug List we provided electronically on our website.
- Visit our website **(kp.org/seniorrx)**. Our Drug List (**2023 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 (**2023 Comprehensive Formulary**) or to ask for a copy of the list.

Section 4 — There are restrictions on coverage for some drugs

Section 4.1 – Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective ways. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

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

Section 4.2 – What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9.)

Restricting brand-name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand-name drug and usually costs less. When a generic version of a brand-name drug is available, our network pharmacies will provide you the generic version instead of the brand-name drug. However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand-name drug. (Your share of the cost may be greater for the brand-name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan before we will agree to cover the drug for you. This is called "prior authorization." This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by our plan.

Section 5 — What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 – There are things you can do if your drug is not covered in the way you'd like it to be covered

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand-name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- The drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be.

- There are things you can do if your drug is not covered in the way that you'd like it to be covered.
  - If your drug is not on our Drug List or if your drug is restricted, go to Section 5.2 in this chapter to learn what you can do.
  - If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 in this chapter to learn what you can do.

Section 5.2 – What can you do if your drug is not on our Drug List or if the drug is restricted in some way?

If your drug is not on our Drug List or is restricted, here are options:

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

You may be able to get a temporary supply

Under certain circumstances, our plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

To be eligible for a temporary supply, the drug you have been taking must no longer be on our Drug List or is now restricted in some way.

- **If you are a new member**, we will cover a temporary supply of your drug during the first 90 days of your membership in our plan.
- **If you were in our plan last year:** We will cover a temporary supply of your drug during the first 90 days of the calendar year.
  - This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in our plan for more than 90 days and reside in a long-term care facility and need a supply right away:** We will cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- **For current members with level of care changes:** If you enter into or are discharged from a hospital, skilled nursing facility, or long-term care facility to a different care setting or home, this is what is known as a level of care change. When your level of care changes, you may require an additional fill of your medication. We will generally cover up to a one-month supply of your Part D drugs during this level of care transition period even if the drug is not on our Drug List.

For questions about a temporary supply, call Member Services.

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

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by our plan that may work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

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

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

Section 5.3 – What can you do if your drug is in a cost-sharing tier you think is too high?

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

You can change to another drug

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

You can ask for an exception

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

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

Drugs in our specialty tier (Tier 5) are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

Section 6 — What if your coverage changes for one of your drugs?

Section 6.1 – The Drug List can change during the year

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

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

Section 6.2 – What happens if coverage changes for a drug you are taking?

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 on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

Changes to your drug coverage that affect you during the current plan year

- A new generic drug replaces a brand-name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand-name drug or both).
  - We may immediately remove a brand-name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand-name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions or both when the new generic is added.
  - We may not tell you in advance before we make that change—even if you are currently taking the brand-name drug. If you are taking the brand-name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand-name drug. You may not get this notice before we make the change.
  - You or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 9.
- Unsafe drugs and other drugs on the Drug List that are withdrawn from the market.
  - Sometimes a drug may 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 are taking that drug, we will tell you right away.
  - Your prescriber will also know about this change and can work with you to find another drug for your condition.
- 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 might add a generic drug that is not new to the market to replace a brand-name drug on the Drug List or change the cost-sharing tier or add new restrictions to the brand-name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
- For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a 30-day refill of the drug you are taking at a network pharmacy.
- After you receive notice of the change, you should work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
- You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9.

Changes to the Drug List that do not affect you during this plan year

We may make certain changes to the Drug List that are not described above. In these cases, the change will not apply to you if you are 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 will not 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 to a drug you are taking (except for market withdrawal, a generic drug replacing a brand-name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restrictions to your use of the drug.

We will not tell you about these types of changes directly during the current plan year. You will 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 the drugs you are taking that will impact you during the next plan year.

Section 7 — What types of drugs are not covered by our plan?

Section 7.1 – Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

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

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
  - Coverage for "off-label use" is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

In addition, by law, the following categories of drugs are not covered by Medicare drug plans:

- Nonprescription drugs (also called over-the-counter drugs).
- Drugs used to promote fertility.
- Drugs used for the relief of cough or cold symptoms.
- Drugs used for cosmetic purposes or to promote hair growth.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Drugs used for the treatment of sexual or erectile dysfunction.
- Drugs used for treatment of anorexia, weight loss, or weight gain.
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.
- We offer additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan (enhanced drug coverage). The amount you pay when you fill a prescription for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 7 of this document.)
- In addition, if you are receiving "Extra Help" from Medicare to pay for your prescriptions, the Extra Help program will not pay for the drugs not normally covered. Please refer to our Drug List or call Member Services for more information. Phone numbers for Member Services are printed on the back cover of this document.

However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

Section 8 — Filling a prescription

Section 8.1 – Provide your membership information

To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will

automatically bill us for our share of your drug cost. You will need to pay the pharmacy your share of the cost when you pick up your prescription.

Section 8.2 – What if you don't have your membership information with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call our plan to get the necessary information.

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

Section 9 — Part D drug coverage in special situations

Section 9.1 – What if you're in a hospital or a skilled nursing facility for a stay that is covered by our plan?

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

Section 9.2 – What if you're a resident in a long-term care (LTC) facility?

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

Check your **Pharmacy Directory** to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Member Services. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our Drug List or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3 – Special note about "creditable coverage"

Each year your employer or retiree group should send you a notice that tells you if your prescription drug coverage for the next calendar year is "creditable."

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

Keep this notice about creditable coverage because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you

have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from your employer or retiree plan's benefits administrator or the employer or union.

Section 9.4 – What if you're in Medicare-certified hospice

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, laxative, pain medication or antianxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

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

Section 10 — Programs on drug safety and managing medications

Section 10.1 – Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting 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 such as:

- Possible medication errors.
- Drugs that may not be necessary because you are taking another 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 are allergic to.
- Possible errors in the amount (dosage) of a drug you are taking.
- Unsafe amounts of opioid pain medications.

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

Section 10.2 – Drug Management Program (DMP) to help members safely use their 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 doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications

is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not 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 doctor(s).
- Limiting the amount of opioid or benzodiazepine medications we will cover for you.

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will explain the limitations we think should apply to you. You will have an opportunity to tell us which doctors 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 will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our determination or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3 – Medication Therapy Management (MTM) program to help members manage their 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 that our members get the most benefit from the drugs they take.

Some members who take medications for different medical conditions and have high drug costs or are in a DMP to help members use their opioids safely, may be able to get services through an MTM 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 receive 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. Also, 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 will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Member Services.

Chapter 6 — What you pay for your Part D prescription drugs

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs does not apply to you.** We sent you a separate document, 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 rider, please call Member Services and ask for the "LIS Rider."

Section 1 — Introduction

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

This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs—some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law. Some excluded drugs may be covered under your group's plan.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4, explain these rules.

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

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called "cost-sharing" and there are three ways you may be asked to pay.

- The **"deductible"** is the amount you pay for drugs before our plan begins to pay its share.
- **"Copayment"** is a fixed amount you pay each time you fill a prescription.
- **"Coinsurance"** is a percentage of the total cost you pay each time you fill a prescription.

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

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

These payments are included in your out-of-pocket costs

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

- The amount you pay for drugs when you are in the Initial Coverage Stage.
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments yourself, they are included in your out-of-pocket costs.
- These payments are also included if they are made on your behalf by certain other individuals or organizations. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some payments made by the Medicare Coverage Gap Discount Program are also included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs, if any, is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of **$7,400** in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments are not included in your out-of-pocket costs

Your out-of-pocket costs do not 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 are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.
- Payments you make toward drugs under our additional prescription drug coverage but not normally covered in a Medicare prescription drug plan.
- Payments you make toward prescription drugs not normally covered in a Medicare prescription drug plan.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

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

How can you keep track of your out-of-pocket total?

- We will help you. The **Part D EOB** report you receive includes the current amount of your out-of-pocket costs. When this amount reaches **$7,400**, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.

- Make sure we have the information we need. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up-to-date.

Section 2 — What you pay for a drug depends upon which "drug payment stage" you are in when you get the drug

Section 2.1 – What are the drug payment stages for Senior Advantage members?

There are four "drug payment stages" for your prescription drug coverage under our plan. How much you pay depends on which stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage (Because there is no deductible for our plan, this payment stage does not apply to you.)

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage (Because there is no coverage gap for our plan, this payment stage does not apply to you.)

Stage 4: Catastrophic Coverage Stage

Important Message About What You Pay for Insulin – You won't pay more than **$35** for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Section 3 — We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 – We send you a monthly summary called the Part D Explanation of Benefits (the "Part D EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **"out-of-pocket"** cost.
- We keep track of your **"total drug costs."** This is the amount you pay out-of-pocket, or others pay on your behalf plus the amount paid by the plan.

If you have had one or more prescriptions filled through the plan during the previous month, we will send you a **Part D Explanation of Benefits** ("Part D EOB"). The Part D EOB includes:

- **Information for that month.** This report gives you the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.

- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower-cost alternative prescriptions.** This will include information about other available drugs with lower cost-sharing for each prescription claim.

Section 3.2 – 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 is 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 us make sure we know about the prescriptions you are filling and what you are paying.
- **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 will not 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. Here are 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 using a discount card that is not part of our plan's benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
  - Anytime you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
  - If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals 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 most 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 receive 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 any questions, please call Member Services. You can also choose to view your **Part D EOB** online instead of by mail. Please visit **kp.org/goinggreen** and sign on to learn more about choosing to view your **Part D EOB** securely online. Be sure to keep these reports.

Section 4 — There is no deductible for Senior Advantage

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

Section 5 — During the Initial Coverage Stage, we pay our share of your drug costs, and you pay your share

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

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

Our plan has six cost-sharing tiers

Every drug on our plan's Drug List is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Cost-sharing **Tier 1** for preferred generic drugs (this tier includes some brand-name drugs).
- Cost-sharing **Tier 2** for generic drugs (this tier includes some brand-name drugs).
- Cost-sharing **Tier 3** for preferred brand-name drugs.
- Cost-sharing **Tier 4** for nonpreferred brand-name drugs (this tier includes some generic drugs).
- Cost-sharing **Tier 5** for specialty-tier drugs (this tier includes both generic and brand-name drugs).
- Cost-sharing **Tier 6** for injectable Part D vaccines (this tier includes only brand-name drugs).

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

Your pharmacy choices

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

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

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 and our plan's **Pharmacy Directory**.

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

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

As shown in the Medical Benefits Chart found at the front of this **EOC**, the amount of the copayment or coinsurance depends on the cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment. Refer to the Medical Benefits Chart found at the front of this **EOC** for your cost-sharing amounts.

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

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

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.

If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.

Section 5.4 – Your costs for a long-term (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply"). A long-term supply is up to a 90-day supply.

Refer to the Medical Benefits Chart found at the front of this **EOC** for your cost-sharing amounts when you get a long-term supply of a drug.

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

Section 5.5 – You stay in the Initial Coverage Stage until your total drug costs for the year reach $7,400

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the **$7,400** limit for the Initial Coverage Stage. You then move on to the Catastrophic Coverage Stage.

We offer additional coverage on some prescription drugs that are not normally covered in a Medicare prescription drug plan. Payments made for these drugs will not count toward your total out-of-pocket costs.

The **Part D EOB** that you receive will help you keep track of how much you, our plan, and any third parties have spent on your behalf during the year. Many people do not reach the **$7,400** limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

Section 6 — There is no coverage gap for our plan

There is no coverage gap for our plan. Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage (see Section 7).

Section 7 — During the Catastrophic Coverage Stage, we pay most of the cost for your drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the **$7,400** limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

Refer to the Medical Benefits Chart found at the front of this **EOC** for your cost-sharing amounts after your out-of-pocket costs have reached the **$7,400** limit for the calendar year.

Section 8 — Part D vaccines. What you pay for depends upon how and where you get them

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

There are two parts to our coverage of Part D vaccinations:

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

Your costs for a Part D vaccination depend on three things:

- The type of vaccine (what you are being vaccinated for).
  - Some vaccines are considered medical benefits. (See the Medical Benefits Chart found at the front of this **EOC**).
  - Other vaccines are considered Part D drugs. You can find these vaccines listed in our Drug List (Formulary).
- Where you get the vaccine.
  - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
- Who gives you the vaccine.
  - A pharmacist may give the vaccine in the pharmacy, or another provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what drug stage you are in.

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask us to pay you back for our share of the cost.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit.

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

- Situation 1: You get your vaccination at the network pharmacy. (Whether you have this choice depends upon where you live. Some states do not allow pharmacies to give vaccines.)
  - You will pay the pharmacy your copayment for the vaccine itself, which includes the cost of giving you the vaccine.
  - Our plan will pay the remainder of the costs.
- Situation 2: You get the Part D vaccination at your doctor's office.
  - When you get the vaccine, you will pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
  - You can then ask us to pay our share of the cost by using the procedures that are described in Chapter 7.
  - You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration).
- Situation 3: You buy the Part D vaccine itself at your pharmacy, and then take it to your doctor's office where they give you the vaccine.
  - You will have to pay the pharmacy your copayment for the vaccine itself.
  - When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask us to pay our share of the cost by using the procedures described in Chapter 7.
  - You will be reimbursed the amount charged by the doctor for administering the vaccine.

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

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

Section 1 — Situations in which you should ask us to pay our share of the cost of your 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 that you have paid more than you expected under the coverage rules of our plan. In these cases, you can ask us to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of cost-sharing as discussed in this document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will 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.

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

When you've received emergency or urgently needed medical care from a provider who is not in our network

You can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases:

- You are 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 accidentally pay the entire amount yourself at the time you receive 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 have made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

When a network provider sends you a bill you think you should not pay

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

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

If you are retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. (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 will need to submit paperwork such as receipts and bills for us to handle the reimbursement.

When you use an out-of-network pharmacy to get a prescription filled

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

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5, for a discussion of these circumstances.

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

If you do not have your plan membership card with you, you can ask the pharmacy to call us or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

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

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on our **2023 Comprehensive Formulary;** or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this document has information about how to make an appeal.

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

You may request 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 received the service, item, or drug.

To make sure you are 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 are 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 will 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 together with any bills or paid receipts to us at this address:

Kaiser Permanente
Claims Department
Northwest Region
P.O. Box 370050
Denver, CO 80237-9998

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

Section 3.1 – We check to see whether we should cover the service or drug and how much we owe

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

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

Section 3.2 – If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal

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

The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9 of this document.

Chapter 8 — Your rights and responsibilities

Section 1 — We must honor your rights and cultural sensitivities as a member of our plan

Section 1.1 – We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English or in large print)

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 may meet these accessibility requirements include, but are not 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 large print at no cost if you need it. We are required to give you information about our plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services.

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

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

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

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

You have the right to get appointments and covered services from our network of providers within a reasonable amount of time. This includes the right to get timely services from specialists

when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells you what you can do.

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

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

- Your "personal health information" includes the personal information you gave us when you enrolled in our 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 you about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- 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.
- Your health information is shared with your group only with your authorization or as otherwise permitted by law.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - We are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information, including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

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

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

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

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

If you want any of the following kinds of information, please 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.**
  - Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.**
  - Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted.
  - Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 – We must support your right to make decisions about your care

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

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

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

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

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

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

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

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

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

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form 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 are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital.

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with (in Oregon) the Division of Financial Regulation, Consumer Advocacy Unit, **1-503-947-7984** or **1-888-877-4894**; or (in Washington) the Washington State Department of Health, **1-360-236-4700**.

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

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

Section 1.7 – What can you do if you believe you are being treated unfairly or your rights are not being respected?

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

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

Is it about something else?

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

- You can call Member Services.
- You can call the SHIP. For details, go to Chapter 2, Section 3.
- Or you can call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week (TTY **1-877-486-2048**).

Section 1.8 – How to get more information about your rights

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

- **You can call Member Services.**
- **You can call the SHIP.** For details, go to Chapter 2, Section 3.
- **You can contact Medicare:**
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at **www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.**)
  - Or you can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week (TTY **1-877-486-2048**).

Section 1.9 – Information about new technology assessments

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

Section 1.10 – You can make suggestions about rights and responsibilities

As a member of our plan, you have the right to make recommendations about the rights and responsibilities included in this chapter. Please call Member Services with any suggestions.

Section 2 — You have some responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. If you have any questions, please call Member Services.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this **Evidence of Coverage** to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapter 3 and Chapter 4 give the details about your medical services.
  - Chapters 5 and 6 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.**
  - Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription 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 care providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you are responsible for these payments:
  - You must pay your plan premiums.
  - You must continue to pay a premium for your Medicare Part B to remain 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 are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

- If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of our plan.

- **If you move within your plan's 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 of your plan's service area**, you cannot remain a member of our plan.
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

Chapter 9 — What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)

Section 1 — Introduction

Section 1.1 – What to do if you have a problem or concern

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

The guide in Section 3 of this chapter will help you identify the right process to use and what you should do.

Other dispute resolution options

Your group may have chosen to cover benefits that are not covered by Medicare. For any such benefits, Medicare rules do not apply (including the Medicare appeal process). If you have an issue relating to a benefit covered by your group plan that is not covered by Medicare, please contact Member Services for information about our non-Medicare appeal process for non-Medicare coverage issues.

Section 1.2 – What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says, "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination" or "coverage determination," or "at-risk determination," and "independent review organization" instead of "Independent Review Entity."
- It also uses abbreviations as little as possible.

However, it can be helpful, and sometimes quite important, for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

Section 2 — Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to Member Services for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

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 are having. They can also answer your questions, give you more information, and offer guidance on what to do.

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

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
- You can also visit the Medicare website (**www.medicare.gov**).

Section 3 — To deal with your problem, which process should you use?

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

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care or prescription drugs are covered or not, the way they are covered, and problems related to payment for medical care or prescription drugs.

- **Yes.**
  - Go to the next section in this chapter, Section 4: "A guide to the basics of coverage decisions and appeals."
- **No.**
  - Skip ahead to Section 10 at the end of this chapter: "How to make a complaint about quality of care, waiting times, customer service, or other concerns."

COVERAGE DECISIONS AND APPEALS

Section 4 — A guide to the basics of coverage decisions and appeals

Section 4.1 – Asking for coverage decisions and making appeals—The big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for medical services and prescription drugs, including payment. This is the process you use for issues such as whether something is covered or not, and the way in which something is covered.

Asking for coverage decisions prior to receiving services

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. 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 will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

Making an appeal

If we make a coverage decision, whether before or after a service is received, and you are not satisfied, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request 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 were properly following the rules. When we have completed 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 will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. (Appeals for medical services and Part B drugs will be automatically sent to the independent review organization for a Level 2 appeal – you do not need to do anything. For Part D drug appeals, if we say no to all or part of your appeal you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 6 of this chapter.) If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 9 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 – How to get help when you are 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:

- You **can call us at Member Services**.
- You **can 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 will need to be appointed as your representative. Please call Member Services and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **kp.org**.
  - For medical care or Medicare Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - 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 on Medicare's website at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **kp.org**.) The form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form.
  - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also

groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision.

Section 4.3 – Which section of this chapter gives the details for your situation?

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

- **Section 5** in this chapter: "Your medical care: How to ask for a coverage decision or make an appeal."
- **Section 6** in this chapter: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal."
- **Section 7** in this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon."
- **Section 8** in this chapter: "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 section you should be using, please call Member Services. You can also get help or information from government organizations such as your SHIP.

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

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

This section is about your benefits for medical care and services. These benefits are described in the Medical Benefits Chart found at the front of this **EOC**. To keep things simple, we generally refer to "medical care coverage" or "medical care," which includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Medicare Part B prescription drug. In those cases, we will explain how the rules for Medicare Part B prescription drugs are different from the rules for medical items and services.

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

- You are not getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
- We will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
- You have received medical care that you believe should be covered by our plan, but we have said we will not pay for this care. **Make an appeal. Section 5.3.**

- You have received and paid for medical care that you believe should be covered by our plan, and you want to ask us to reimburse you for this care. **Send us the bill. Section 5.5.**
- You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 7 and 8 of this chapter. Special rules apply to these types of care.

Section 5.2 – Step-by-step: How to ask for a coverage decision

Legal Terms	When a coverage decision involves your medical care, it 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 14 days 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. In order to get a fast coverage decision, you must meet two requirements:

- You may only ask for coverage for medical care you have not yet received.
- You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.
- If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision. If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor asks for the fast coverage decision, we will 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 requested.

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

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

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

For standard coverage decisions, we use the standard deadlines.

This means we will give you an answer within 14 calendar days after we receive your request **for a medical item or service**. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** after we receive your request.

- However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint." We will 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. See Section 10 of this chapter for information on complaints.)

For fast coverage decisions we use an expedited time frame.

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

- However, if you ask for more time, or if we need more that may benefit you, **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint." (See Section 10 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 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 are going on to Level 1 of the appeals process.

Section 5.3 – Step-by-step: How to make a Level 1 appeal

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

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

A "standard appeal" is usually made within 30 days. A "fast appeal" is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal." If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 5.2 of this chapter.

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

- If you are asking for a standard appeal, submit your standard appeal in writing. Chapter 2 has contact information.
- If you are asking for a fast appeal, make your appeal in writing or call us. Chapter 2 has contact information.
- You must make your appeal request within 60 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 requesting 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 are 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 of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed possibly contacting you or your doctor.

Deadlines for a "fast appeal"

- For fast appeals, we must give you our answer **within 72 hours** after we receive your appeal. We will give you our answer sooner if your health requires us to.
  - 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 will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you our decision in writing and 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 receives your appeal.

Deadlines for a "standard appeal"

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

Section 5.4 – Step-by-step: How a Level 2 appeal is done

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

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

Step 1: The independent review organization reviews your appeal.

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

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

- For the "fast appeal," the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.

- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, it can take up to 14 more calendar days. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

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

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

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

- If the review organization says yes to part or all of a request for a medical item or service, we must authorize the medical care coverage **within 72 hours** or provide the service **within 14 calendar days** after we receive the decision from the review organization for standard requests. For expedited requests, we have **72 hours** from the date we receive the decision from the review organization.
- If the review organization says yes to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug **within 72 hours** after we receive the decision from the review organization for standard requests. For expedited requests, we have **24 hours** from the date we receive the decision from the review organization.
- If this organization says no to part or all of your appeal, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal.")
- In this case, the independent review organization will send you a letter:
  - Explaining its decision.
  - Notifying you of the 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.
  - Telling 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 three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter explains the Level 3, 4, and 5 appeals processes.

Section 5.5 – What if you are asking us to pay you for our share of a bill you have received for medical care?

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

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all 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 all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven't paid for the services, we will 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 will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why.

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

To make this appeal, follow the process for appeals that we describe in Section 5.3. For appeals concerning reimbursement, **please note:**

- We must give you our answer within 60 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not 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 requested to you or to the provider within 60 calendar days.

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

Section 6.1 – This section tells you 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. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs, please see Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time. We also use the term "drug list" instead of "List of Covered Drugs" or **2023 Comprehensive Formulary**.

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

Part D coverage decisions and appeals

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

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

- Asking us to cover a Part D drug that is not on our **2023 Comprehensive Formulary. Ask for an exception. Section 6.2.**
- Asking us to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception. Section 6.2.**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2.**
- Asking us to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4.**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4.**

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

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

Section 6.2 – What is an exception?

Legal Terms	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."** Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."** Asking to pay a lower price for a covered nonpreferred drug is sometimes called asking for a **"tiering exception."**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an **"exception."** An exception is a type of coverage decision.

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:

1. **Covering a Part D drug for you that is not on our Drug List.** If we agree to cover a drug not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 4 for nonpreferred brand-name drugs or Tier 2 for generic drugs. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.

2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **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 will 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 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 cannot 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 is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 6.3 – Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

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

We can say yes or no to your request

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

Section 6.4 – Step-by-step: How to ask for a coverage decision, including an exception

Legal Term	A "fast coverage decision" is called an **"expedited coverage determination."**

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

"Standard coverage decisions" are made within **72 hours** after we receive your doctor's statement. "Fast coverage decisions" are made within **24 hours** after we receive 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 two requirements:

- You must be asking for a drug you have not yet received. (You cannot 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 will automatically give you a fast coverage decision.
- **If you ask for a fast coverage decision on your own,** without your doctor's or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision. If we do not approve a fast coverage decision, we will send you a letter that:

- Explains that we will use the standard deadlines.
- Explains if your doctor or other prescriber asks for the fast coverage decision, we will 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 requested. We will answer your complaint **within 24 hours** of receipt.

Step 2: Request a "standard coverage decision" or a "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 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. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor (or other prescriber), or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- If you are requesting 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 receive your request.
  - For exceptions, we will give you our answer **within 24 hours** after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request 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 requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- We must generally give you our answer **within 72 hours** after we receive your request.
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.

- ♦ If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

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

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

- We must give you our answer within 14 calendar days after we receive your request.
  - ♦ If we do not meet this deadline, we are required to send your request 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 requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 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 are going to Level 1 of the appeals process.

Section 6.5 – Step-by-step: How to make a Level 1 appeal

Legal Terms	An appeal to our plan about a Part D drug coverage decision is called a plan **"redetermination."** A "fast appeal" is also 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 days. A "fast appeal" is generally made within 72 hours. If your health requires it, ask for a "fast appeal"

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 of this chapter.

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

- For standard appeals, submit a written request. Chapter 2 has contact information.

- For fast appeals either submit your appeal in writing or call us at **1-877-221-8221**. Chapter 2 has contact information.
- We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- You must make your appeal request within 60 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 requesting 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 are 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 we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires us to.
  - If we do not give you an answer **within 72 hours**, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide **within 72 hours** after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a "standard appeal" for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

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

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request 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 requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

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

Section 6.6 – Step-by-step: How to make a Level 2 appeal

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

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

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

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

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all of the information related to 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 review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For "fast appeals":

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

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 review organization **within 72 hours** after we receive the decision from the 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 are required to send payment to you **within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to 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 is also called "turning down your appeal."). In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling 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 three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7 — How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will 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 are being asked to leave the hospital too soon, you can ask for a longer hospital stay, and your request will be considered.

Section 7.1 – During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, you will be given a written notice called **An Important Message from Medicare about Your Rights.** Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Member Services or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week (TTY **1-877-486-2048**).

- **Read this notice carefully** and ask questions if you don't understand it. It tells you:
  - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
  - Your right to be involved in any decisions about your hospital stay.
  - 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 are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.
- **You will be asked to sign the written notice** to show that you received it and understand your rights.
  - You or someone who is acting on your behalf will be asked to sign the notice.
  - Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.

- **Keep your copy** of the notice handy so you will 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 two days before your discharge date, you will get another copy before you are scheduled to be discharged.
  - To look at a copy of this notice in advance, you can call Member Services or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. You can also see the notice online at **www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices**.

Section 7.2 – Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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 are not 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 received **(An Important Message from Medicare About Your Rights)** tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly

- To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and **no later than midnight the day of your discharge**.
  - **If you meet this deadline,** you may 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 do not meet this deadline,** and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you receive after your planned discharge date.

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Once you request an immediate review of your hospital discharge, the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will 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)**, 24 hours a day, 7 days a week. (TTY users should call **1-877-486-2048**.) Or you can see a sample notice online at **www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices**.

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 may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives you 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 review organization says yes, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the review organization says **no**, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for **your inpatient hospital services will end** at noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

- If the review organization says no to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost of hospital care** you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

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

Section 7.3 – Step-by-step: 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 their 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 that your coverage for the care ended.

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

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

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

If the review organization says yes:

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

If the review organization says no:

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 – What if you miss the deadline for making your Level 1 appeal?

Legal Term	A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge date. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

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

Step-by-step: How to make a Level 1 alternate appeal

Step 1: Contact us and ask for a "fast review."

- **Ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines. Chapter 2 has contact information.

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

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will see if the decision about when you should leave the hospital was fair and followed all the rules.

Step 3: We give you our decision within 72 hours **after you ask for a "fast review."**

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
- **If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you received after the planned discharge date.**

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

Step-by-step: Level 2 alternate appeal process

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

The independent review organization is an independent organization hired by Medicare. It is not connected with our plan 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: We will automatically forward your case to the independent review organization. We are required to send the information for your Level 2 appeal to the independent review organization **within 24 hours** of when we tell you that we are saying **no** to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 in this chapter tells you how to make a complaint.)

Step 2: The independent review organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal**, then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue our plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal**, it means they agree that your planned hospital discharge date was medically appropriate.
  - The written notice you get from the independent review organization will tell how to start a Level 3 appeal with the review process, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say **no** to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 8 — How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 – This section is only about three services: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

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

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

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

Section 8.2 – We will tell you in advance when your coverage will be ending

Legal Term	"**Notice of Medicare Non-Coverage**." It tells you how you can request a "**fast-track appeal**." Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:

- The date when we will stop covering the care for you.
- How to request a "fast track appeal" to request us to keep covering your care for a longer period of time.

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

Section 8.3 – Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

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

- **Follow the process.**
- **Meet the deadlines.**

- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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 who are 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 are not 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 received (**Notice of Medicare Non-Coverage**) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the **Notice of Medicare Non-Coverage**.

Your deadline for contacting this organization.

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5.

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

Legal Term	**"Detailed Explanation of Non-Coverage."** Notice that provides 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 may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers tell us of your appeal, you will 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 is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say **no**, then **your coverage will end** on the date we have 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, **then you will have to pay the full cost of this care yourself.**

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

- If reviewers say no to your Level 1 appeal, and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 appeal.

Section 8.4 – Step-by-step: 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 days after the day when the Quality Improvement Organization said **no** to your Level 1 appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

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

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

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

What happens if the review organization says yes?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue** providing coverage for the care for as long as it is medically necessary.

- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

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

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 8.5 – What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

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

Legal Term	A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

Step 1: Contact us and ask for a "fast review."

- **Ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines. Chapter 2 has contact information.

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

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending our plan's coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a "fast review."

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

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

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

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

Step-by-step: Level 2 Alternate appeal process

During the Level 2 appeal, the independent review organization reviews the decision we made to your "fast appeal." This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization **within 24 hours** of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells you how to make a complaint.)

Step 2: The independent review organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

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

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If 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.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 9 — Taking your appeal to Level 3 and beyond

Section 9.1 – Appeal Levels 3, 4, and 5 for Medical Service Requests

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

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

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

Level 3 appeal: 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 is 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 service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. 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 will 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 service within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you 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 on 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 of the information and decide yes or no to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 9.2 – Appeal Levels 3, 4, and 5 for Part D Drug Requests

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

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

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

Level 3 appeal: 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 receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

- If you do not want to accept the decision, you can continue to the next level of the review process. 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 receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you 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 whom to contact and what to do next if you choose to continue with your appeal.

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

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

MAKING COMPLAINTS

Section 10 — How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 – What kinds of problems are handled by the complaint process?

The complaint process is only used for certain types of problems. This includes problems related to 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 have received (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 are being encouraged to leave our plan?

- **Waiting times**
  - Are you having trouble getting an appointment, or waiting too long to get it?
  - Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by Member Services or other staff at our plan?
  - Examples include waiting too long on the phone, in the waiting 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 related to the timeliness of our actions related to coverage decisions and appeals)

If you have asked for a coverage decision or made an appeal, and you think that we are not 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 have said no, you can make a complaint.
- You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint.
- You believe we are not 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.

Section 10.2 – How to make a complaint

Legal Terms	• A **"complaint"** is also called a **"grievance."** • **"Making a complaint"** is also called **"filing a grievance."** • **"Using the process for complaints"** is also called **"using the process for filing a grievance."** • A **"fast complaint"** is also called an **"expedited grievance."**

Section 10.3 – Step-by-step: Making a complaint

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

- **Usually calling Member Services is the first step**. If there is anything else you need to do, Member Services will let you know.
- **If you do not wish to call (or you called and were not satisfied),** you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond

to you in writing. We will also respond in writing when you make a complaint by phone if you request a written response or your complaint is related to quality of care.

- **If you have a complaint, we will try to resolve your complaint over the phone.** If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. Your grievance must explain your concern, such as why you are dissatisfied with the services you received. Please see Chapter 2 for whom you should contact if you have a complaint.
  - You must submit your grievance to us (orally or in writing) within 60 calendar days of the event or incident. We must address your grievance as quickly as your health requires, but no later than 30 calendar days after receiving your complaint. We may extend the time frame to make our decision by up to 14 calendar days if you ask for an extension, or if we justify a need for additional information and the delay is in your best interest.
  - You can file a fast grievance about our decision not to expedite a coverage decision or appeal, or if we extend the time we need to make a decision about a coverage decision or appeal. We must respond to your fast grievance **within 24 hours**.
- 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 will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint."** If you have a "fast complaint," it means we will give you an answer **within 24 hours**.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 10.4 – You can also make complaints about quality of care to the Quality Improvement Organization

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

- **You can make your complaint directly to the Quality Improvement Organization**. The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.
- **Or you can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 10.5 – 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/MedicareComplaintForm/home.aspx.** You may also call **1-800-MEDICARE (1-800-633-4227)**. TTY/TDD users can call **1-877-486-2048**.

Chapter 10 — Ending your membership in our plan

Section 1 — Introduction to ending your membership in our plan

Ending your membership in our plan may be voluntary (your own choice) or involuntary (not your own choice):

- You might leave our plan because you have decided that you want to leave.
- There are also limited situations where we are required to end your membership. Section 5 in this chapter tells you about situations when we must end your membership.

If you are leaving our plan, we must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

Section 2 — When can you end your membership in our plan?

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 written, signed, and dated disenrollment request.

Other Medicare health plans

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

The Centers for Medicare & Medicaid Services will let us know if you enroll in another Medicare Advantage health plan, so you will not need to send us a disenrollment request. If you enroll in some other type of Medicare Supplemental coverage, a signed disenrollment request must be received prior to the date of your new coverage, requesting your specific disenrollment date.

Original Medicare

- If you request disenrollment from Senior Advantage and you do not enroll in another Medicare health plan, you will automatically be enrolled in Original Medicare when your Senior Advantage membership terminates (your disenrollment date). On your disenrollment date, you can start using your red, white, and blue Medicare card to get services under

Original Medicare. You will not get anything in writing that tells you that you have Original Medicare after you disenroll. If you choose Original Medicare and you want to continue to get Medicare Part D prescription drug coverage, you will need to enroll in a prescription drug plan.

Section 2.1 – Where can you get more information about when you can end your membership?

If you have any questions about ending your group membership, you can:

- Contact your group's benefits administrator.
- **Call Member Services**.
- You can find the information in the **Medicare & You** 2023 handbook.
- Contact Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week (TTY **1-877-486-2048**).

Section 3 — How do you end your Senior Advantage membership?

You may request disenrollment by:

- Requesting disenrollment with your group's benefits administrator by submitting a signed disenrollment request prior to the date you would like to be terminated. You should always consult them before taking any action because it can affect your eligibility for group benefits.
- Calling toll free **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
- Sending written notice to the following address:

  Kaiser Permanente
  Medicare Department
  P.O. Box 232407
  San Diego, CA 92193-9914

Section 4 — Until your membership ends, you must keep getting your medical services and drugs through our plan

Until your membership ends, and your new Medicare coverage begins, you must continue to get your medical care and prescription drugs through our plan.

- Continue to use our network providers to receive medical care.
- Continue to use our network pharmacies or mail order to get your prescriptions filled.
- If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).

Section 5 — We must end your membership in our plan in certain situations

Section 5.1 – When must we end your membership in our plan?

We must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, call Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get medical care. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information about when we can end your membership, call Member Services.

Section 5.2 – We cannot ask you to leave our plan for any health-related reason

We are not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at **1-800-MEDICARE (1-800-633-4227)** 24 hours a day, 7 days a week. (TTY **1-877-486-2048**).

Section 5.3 – You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

Section 5.4 – What happens if you are no longer eligible for group coverage

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.

- If you are no longer eligible for group membership, you can request enrollment in our Senior Advantage Individual Plan if you still meet the eligibility requirements for Senior Advantage. The premiums and coverage under our individual plan will differ from those under this **EOC** and will include Medicare Part D prescription drug coverage.
- You may not be eligible to enroll in our Senior Advantage individual plan if your membership ends for the reasons stated under Section 5.1. For more information or information about other individual plans, call Member Services. Phone numbers are printed on the back cover of this document.

Chapter 11 — Legal notices

Section 1 — Notice about governing law

The principal law that applies to this **Evidence of Coverage** document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

Section 2 — Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at **1-800-368-1019** (TTY **1-800-537-7697**) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at **https://www.hhs.gov/ocr/index**.

If you have a disability and need help with access to care, please call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Section 3 — Notice about Medicare Secondary Payer subrogation rights

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

Section 4 — Administration of this Evidence of Coverage

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this **Evidence of Coverage**.

Section 5 — Amendment of Agreement

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

Section 6 — Applications and statements

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

Section 7 — Assignment

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

Section 8 — Attorney and advocate fees and expenses

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

Section 9 — Coordination of benefits

As described in Chapter 1, Section 6, "How other insurance works with our plan," if you have other insurance, you are required to use your other coverage in combination with your coverage as a Senior Advantage plan member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. You will get your covered care as usual from network providers, and the other coverage you have will simply help pay for the care you receive.

If your other coverage is the primary payer, it will often settle its share of payment directly with us, and you will not have to be involved. However, if payment owed to us by a primary payer is sent directly to you, you are required by Medicare law to give this primary payment to us. For more information about primary payments in third party liability situations, see Section 17 in this

chapter, and for primary payments in workers' compensation cases, see Section 19 in this chapter.

You must tell us if you have other health care coverage, and let us know whenever there are any changes in your additional coverage.

Section 10 — Employer responsibility

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

Section 11 — Evidence of Coverage binding on members

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

Section 12 — Government agency responsibility

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

Section 13 — Member nonliability

Our contracts with network providers provide that you are not liable for any amounts we owe. However, you are liable for the cost of noncovered services you obtain from network providers or out-of-network providers.

Section 14 — No waiver

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

Section 15 — Notices

Our notices to you will be sent to the most recent address we have. You are responsible for notifying us of any change in your address. If you move, please call Member Services (phone numbers are printed on the back of this document) and Social Security at **1-800-772-1213** (TTY **1-800-325-0778**) as soon as possible to report your address change.

Section 16 — Overpayment recovery

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

Section 17 — Third party liability

As stated in Chapter 1, Section 6, third parties who cause you injury or illness (and/or their insurance companies) usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue these primary payments. If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered services, you must ensure we receive reimbursement for those services.

Note: This "Third party liability" section does not affect your obligation to pay cost-sharing for these services.

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

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain against a third party that results in any settlement proceeds or judgment, from other types of coverage that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, workers' compensation, personal injury, medical payments and all other first party types. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether you are made whole and regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred. We are not required to pay attorney fees or costs to any attorney hired by you to pursue your damages claim. If you reimburse us without the need for legal action, we will allow a procurement cost discount. If we have to pursue legal action to enforce its interest, there will be no procurement discount.

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

Equian, LLC
Attn: Subrogation Operations
P.O. Box 36380
Louisville, KY 40233
Fax: 502-214-1291

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's

liability insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent.

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

Section 18 — U.S. Department of Veterans Affairs

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

Section 19 — Workers' compensation or employer's liability benefits

As stated in Chapter 1, Section 6, workers' compensation usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue primary payments under workers' compensation or employer's liability law. You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered services from the following sources:

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

Section 20 — Surrogacy

In situations where a member receives monetary compensation to act as a surrogate, our plan will seek reimbursement of all Plan Charges for covered services the member receives that are associated with conception, pregnancy and/or delivery of the child. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Chapter 12 — Definitions of important words

Allowance – A specified credit amount that you can use toward the cost of an item. If the cost of the item(s) or service(s) you select exceeds the allowance, you will pay the amount in excess of the allowance, which does not apply to the maximum out-of-pocket amount.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measure your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand-Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand-name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D drug benefit when you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent **$7,400** in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example, 20%) of Plan Charges as your share of the cost for services or prescription drugs after you pay any deductibles.

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 related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Formulary (Formulary or "Drug List") – A list of prescription drugs covered by our plan.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Coordination of Benefits (COB) – Coordination of Benefits is a provision used to establish the order in which claims are paid when you have other insurance. If you have Medicare and other health insurance or coverage, each type of coverage is called a "payer." When there is more than one payer, there are "coordination of benefits" rules that decide which one pays first. The "primary payer" pays what it owes on your bills first, and then sends the rest to the "secondary payer" to pay. If payment owed to us is sent directly to you, you are required under Medicare law to give the payment to us. In some cases, there may also be a third payer. See Chapter 1 (Section 6) and Chapter 11 (Section 9) for more information.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example, $10), rather than a percentage.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received. **Note:** In some cases, you may not pay all applicable cost-sharing at the time you receive the services, and we will send you a bill later for the cost-sharing. For example, if you receive nonpreventive care during a scheduled preventive care visit, we may bill you later for the cost-sharing applicable to the nonpreventive care. For items ordered in advance, you pay the cost-sharing in effect on the order date (although we 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-sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you are required to pay for the prescription. In general, if you take your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this document.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The term we use to mean all of the health care services and items that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily Cost-Sharing Rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Dependent – A member who meets the eligibility requirements as a dependent (for dependent eligibility requirements, see Chapter 1, Section 2).

Disenroll or Disenrollment – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include: walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech-generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

Emergency Care – Covered services that are (1) provided by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Emergency Medical Condition – A medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with

an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a nonpreferred drug at a lower cost-sharing level (a tiering exception).

Excluded Drug – A drug that is not a "covered Part D drug," as defined under 42 U.S.C. Section 1395w-102(e).

Extra Help – A Medicare or a state 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 his or her dependents.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a "generic" drug works the same as a brand-name drug and usually costs less.

Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

Group – The entity with which we have entered into the **Agreement** that includes this **Evidence of Coverage**.

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (for example, bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Medical Benefits Chart found at the front of this **EOC**. We cover home health care in accord with Medicare guidelines. Home health care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services do not include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

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

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached **$7,400**.

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

Inpatient Hospital Care – Health care that you get during an inpatient stay in an acute care general hospital.

Kaiser Foundation Health Plan (Health Plan) – Kaiser Foundation Health Plan of the Northwest is a nonprofit corporation and a Medicare Advantage organization. This **Evidence of Coverage** sometimes refers to Health Plan as "we" or "us."

Kaiser Foundation Hospital – A network hospital owned and operated by Kaiser Foundation Hospitals.

Kaiser Permanente – Health Plan, Medical Group, and Kaiser Foundation Hospitals.

Kaiser Permanente Region (Region) – A Kaiser Foundation Health Plan organization that conducts a direct-service health care program. When you are outside our service area, you can get medically necessary health care and ongoing care for chronic conditions from designated providers in another Kaiser Permanente Region's service area. For more information, please refer to Chapter 3, Section 2.4.

Long-Term Care Hospital – A Medicare-certified acute-care hospital that typically provide Medicare covered services such as comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. They are not long-term care facilities such as convalescent or assisted living facilities.

Low Income Subsidy (LIS) – See "Extra Help."

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for any contribution to your group's monthly premium, your Medicare Part A and Part B premiums, and Part D prescription drugs do not count toward the maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary

from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medical Care or Services – Health care services or items. Some examples of health care items include durable medical equipment, eyeglasses, and drugs covered by Medicare Part A or Part B, but not drugs covered under Medicare Part D.

Medical Group – It is the network of plan providers that our plan contracts with to provide covered services to you. The name of our medical group is Northwest Permanente, P.C., Physicians and Surgeons, a for-profit professional corporation.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be (i) an HMO, (ii) a PPO, (iii) a Private Fee-for-Service (PFFS) plan, or (iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage.**

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand-name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the federal government and certain drug manufacturers.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term "Medicare-covered services" does not include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/ Pilot Programs, and Programs of All-Inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Physician – Any licensed physician who is an employee of Medical Group, or any licensed physician who contracts to provide services to our members (but not including physicians who contract only to provide referral services).

Network Provider – "Provider" is the general term for doctors, other health care professionals (including, but not limited to, physician assistants, nurse practitioners, and nurses), hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. "Network providers" have an agreement with our plan to accept our payment as payment in full, and in some cases, to coordinate as well as provide covered services to members of our plan. Network providers are also called "plan providers."

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this document.

Original 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 two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply (see Chapter 5, Section 2.5, for more information).

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for "Cost-Sharing" above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's "out-of-pocket" cost requirement.

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) for as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – See **"Medicare Advantage (MA) Plan."**

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan.

Plan – Kaiser Permanente Senior Advantage.

Plan Charges – Plan Charges means the following:

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

Post-Stabilization Care – Medically necessary services related to your emergency medical condition that you receive after your treating physician determines that this condition is clinically stable. You are considered clinically stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers

and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (nonpreferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health care or prescription drug coverage.

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services or certain drugs. Covered services that need prior authorization are marked in the Medical Benefits Chart found at the front of this **EOC** and described in Chapter 3, Section 2.3. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – Medical devices including, but are not limited to: arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy and urological supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (nonemergency) services. Our plan must disenroll you if you permanently move out of your plan's service area.

Services – Health care services or items.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Specialty-Tier Drugs – Very high-cost drugs approved by the FDA that are on our formulary.

Subscriber – A member who is eligible for membership on his or her own behalf and not by virtue of dependent status (for subscriber eligibility requirements, see Chapter 1, Section 2).

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

KAISER PERMANENTE®

Kaiser Permanente Senior Advantage Member Services

METHOD	Member Services—contact information
CALL	**1-877-221-8221** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Kaiser Permanente Member Services 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099
WEBSITE	**kp.org**

State Health Insurance Assistance Program

A State Health Insurance Assistance Program (SHIP) is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. Please see Chapter 2, Section 3, for SHIP contact information.

Nondiscrimination Notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. We also:

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

If you need these services, call Member Services at **1-800-813-2000** (TTY: **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at: Member Relations Department, Attention: Kaiser Civil Rights Coordinator, 500 NE Multnomah St. Ste 100, Portland, OR 97232-2099, Phone: **1-800-813-2000** (TTY: **711**), Fax: **1-855-347-7239.**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 2020, Phone: **1-800-368-1019**, TDD: **1-800-537-7697.** Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

For Washington Members

You can also file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal, available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 1-800-562-6900, or 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-877-221-8221** (TTY **711**). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-877-221-8221** (TTY **711**). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 **1-877-221-8221** (TTY **711**)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: **您**對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 **1-877-221-8221** (TTY **711**)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-877-221-8221** (TTY **711**). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-877-221-8221** (TTY **711**). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1-877-221-8221** (TTY **711**) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-877-221-8221** (TTY **711**). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

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Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-877-221-8221** (TTY **711**) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-877-221-8221** (TTY **711**). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-877-221-8221** (TTY **711**) سيقوم شخص ما يتحدث بمساعدتك. هذه خدمة مجانية العربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1-877-221-8221** (TTY **711**) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-877-221-8221** (TTY **711**). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-877-221-8221** (TTY **711**). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-877-221-8221** (TTY **711**). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-877-221-8221** (TTY **711**). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、**1-877-221-8221** (TTY **711**) にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

Acupuncture Services Rider
Kaiser Permanente Senior Advantage (HMO)

This rider is part of the **Kaiser Permanente Senior Advantage (HMO) Evidence of Coverage (EOC)** to which it is attached. All provisions of this rider become part of the **EOC** "Chapter 4: Medical Benefits Chart (what is covered and what you pay)" section. This entire benefit rider is therefore subject to all the terms and provisions of the **EOC**.

We cover the services described in this "Acupuncture Services Rider" when services are received from a network provider and provided as outpatient services in the network provider's office.

To locate a network provider, visit **www.chpgroup.com**. If you need assistance searching for a network provider, or to verify the current participation status of a provider, or if you do not have access to the online directory, please contact Member Services.

If a benefit maximum is listed in the Medical Benefits Chart "Alternative care therapies (self-referred)" section, you are responsible for paying the full amount for services after you reach the benefit maximum.

Services are subject to any visit limits and applicable cost-sharing listed in the Medical Benefits Chart "Alternative care therapies (self-referred)" section.

Acupuncture services

Acupuncturists influence the health of the body by the insertion of very fine needles. Acupuncture treatment is primarily used to relieve pain, reduce inflammation, and promote healing. Covered services include:

- Evaluation and management.
- Acupuncture.
- Electro acupuncture.

Acupuncture services rider exclusions

- Dermal friction technique.
- East Asian massage and tui na.
- Laserpuncture.
- Nambudripad allergy elimination technique (NAET).
- Point injection therapy.
- Qi gong.
- Services designed to maintain optimal health in the absence of symptoms.
- Sonopuncture.

Chiropractic Services Rider
Kaiser Permanente Senior Advantage (HMO)

This rider is part of the **Kaiser Permanente Senior Advantage (HMO) Evidence of Coverage (EOC)** to which it is attached. All provisions of this rider become part of the **EOC** "Chapter 4: Medical Benefits Chart (what is covered and what you pay)" section. This entire benefit rider is therefore subject to all the terms and provisions of the **EOC**.

We cover the services described in this "Chiropractic Services Rider" when services are received from a network provider and provided as outpatient services in the network provider's office.

To locate a network provider, visit **www.chpgroup.com**. If you need assistance searching for a network provider, or to verify the current participation status of a provider, or if you do not have access to the online directory, please contact Member Services.

If a benefit maximum is listed in the Medical Benefits Chart "Alternative care therapies (self-referred)" section, you are responsible for paying the full amount for services after you reach the benefit maximum.

Services are subject to any visit limits and applicable cost-sharing listed in the Medical Benefits Chart "Alternative care therapies (self-referred)" section.

Chiropractic services

Chiropractic and manual manipulation of the spine, joints, or soft tissue focuses on reducing pain and improving the function and structure of the body. It is a system of therapy that involves non-invasive care promoting science-based approaches to a variety of ailments. Covered services include:

- Evaluation and management.
- Musculoskeletal treatments.
- Physical therapy modalities such as hot and cold packs.

When prescribed by a network provider, X-ray procedures are covered as described in the Medical Benefits Chart "Outpatient diagnostic tests and therapeutic services and supplies" section.

Chiropractic services rider exclusions

- Dermal friction technique.
- East Asian massage and tui na.
- Nambudripad allergy elimination technique (NAET).
- Qi gong.
- Services designed to maintain optimal health in the absence of symptoms.
- Sonopuncture.

Massage Therapy Rider
Kaiser Permanente Senior Advantage (HMO)

This rider is part of the **Kaiser Permanente Senior Advantage (HMO) Evidence of Coverage (EOC)** to which it is attached. All provisions of this rider become part of the **EOC** "Chapter 4: Medical Benefits Chart (what is covered and what you pay)" section. This entire benefit rider is therefore subject to all the terms and provisions of the **EOC**.

We cover the services described in this "Massage Therapy Rider" when services are received from a network provider and provided as outpatient services in the network provider's office.

To locate a network provider, visit **www.chpgroup.com**. If you need assistance searching for a network provider, or to verify the current participation status of a provider, or if you do not have access to the online directory, please contact Member Services.

If a benefit maximum is listed in the Medical Benefits Chart "Alternative care therapies (self-referred)" section, you are responsible for paying the full amount for services after you reach the benefit maximum.

Services are subject to any visit limits and applicable cost-sharing listed in the Medical Benefits Chart "Alternative care therapies (self-referred)" section.

Massage therapy

Therapeutic massage involves the manipulation of soft tissue structures of the body to help alleviate pain, muscle discomfort, and stress by helping to promote health and wellness. Covered services include therapeutic massage procedures.

Massage therapy rider exclusions

- Dermal friction technique.
- East Asian massage and tui na.
- Qi gong.
- Services designed to maintain optimal health in the absence of symptoms.

Naturopathic Medicine Rider
Kaiser Permanente Senior Advantage (HMO)

This rider is part of the **Kaiser Permanente Senior Advantage (HMO) Evidence of Coverage (EOC)** to which it is attached. All provisions of this rider become part of the **EOC** "Chapter 4: Medical Benefits Chart (what is covered and what you pay)" section. This entire benefit rider is therefore subject to all the terms and provisions of the **EOC**.

We cover the services described in this "Naturopathic Medicine Rider" when services are received from a network provider and provided as outpatient services in the network provider's office.

To locate a network provider, visit **www.chpgroup.com**. If you need assistance searching for a network provider, or to verify the current participation status of a provider, or if you do not have access to the online directory, please contact Member Services.

If a benefit maximum is listed in the Medical Benefits Chart "Alternative care therapies (self-referred)" section, you are responsible for paying the full amount for services after you reach the benefit maximum.

Services are subject to any visit limits and applicable cost-sharing listed in the Medical Benefits Chart "Alternative care therapies (self-referred)" section.

Naturopathic medicine

Naturopathic medicine is a natural approach to health and healing which emphasizes a holistic approach to the diagnosis, treatment, and prevention of illness. Naturopathic physicians diagnose and treat patients by using natural modalities such as clinical nutrition, herbal medicine, and homeopathy. Covered services include:

- Evaluation and management.
- Health condition related treatments.
- Physical therapy modalities such as hot and cold packs.

When prescribed by a network provider, certain laboratory procedures are covered as described in the Medical Benefits Chart "Outpatient diagnostic tests and therapeutic services and supplies" section.

Hearing Aid Rider
Kaiser Permanente Senior Advantage (HMO)

This rider is part of the **Kaiser Permanente Senior Advantage (HMO)** Evidence of Coverage (EOC) to which it is attached. All provisions of this rider become part of the **EOC** "Chapter 4: Medical Benefits Chart (what is covered and what you pay)" section. This entire benefit rider is therefore subject to all the terms and provisions of the **EOC**.

Hearing aids

We cover hearing aids, visits to determine the appropriate hearing aid model, visits to verify that the hearing aid conforms to the prescription, and visits for fitting, counseling, adjustment, cleaning, and inspection. These services are covered only when received from network providers.

Hearing exams to determine the need for hearing correction and to provide a prescription for hearing aids are not covered under this "Hearing Aid Rider" (see "Hearing services" in the Medical Benefits Chart).

We provide an allowance toward the price of a hearing aid or aids. The allowance and your cost-sharing, if any, are listed in the Medical Benefits Chart "Hearing services, Hearing aids" section. You do not have to use the allowance for both ears at the same time, but we will not provide the allowance for an ear if we have previously covered a hearing aid for that ear within the allowance period under this or any other evidence of coverage (including riders) with the same group number printed on the Medical Benefits Chart.

The date we cover a hearing aid is the date on which you are fitted for the hearing aid. If you are fitted for a hearing aid while you are covered under this **EOC**, and if we would otherwise cover the hearing aid, we will cover the hearing aid even if you do not receive the hearing aid until after you are no longer covered under this **EOC**.

Covered hearing aids are electronic devices worn on the person for the purpose of amplifying sound and assisting in the process of hearing, including an ear mold, if necessary, and are limited to one of the following digital models: (i) in-the-ear; (ii) behind-the-ear; (iii) on-the-body (Body Aid Model); or (iv) canal/CIC aids.

Hearing aid rider exclusions

- Bone anchored hearing aids.
- Cleaners, moisture guards, and assistive listening devices (for example, FM systems, cell phone or telephone amplifiers, and personal amplifiers designed to improve your ability to hear in a specific listening situation).
- Hearing aids that were fitted before you were covered under this **EOC** (for example, a hearing aid that was fitted during the previous contract year will not be covered under this **EOC**, though it might be covered under your evidence of coverage for the previous contract year).
- Internally implanted hearing aids.
- Repair of hearing aids beyond the warranty period.

- Replacement of lost or broken hearing aids, if you have exhausted (used up) your allowance.
- Replacement parts and batteries.

Prescription Eyewear Rider
Kaiser Permanente Senior Advantage (HMO)

This rider is part of the **Kaiser Permanente Senior Advantage (HMO) Evidence of Coverage (EOC)** to which it is attached. All provisions of this rider become part of the **EOC** "Chapter 4: Medical Benefits Chart (what is covered and what you pay)" section. This entire benefit rider is therefore subject to all the terms and provisions of the **EOC**.

We cover the services listed in this rider at network optical centers when prescribed by a network provider or an out-of-network provider.

Eyeglasses and contact lenses

We provide an allowance toward the price of prescription eyeglass lenses and a frame, or conventional or disposable prescription contact lenses, including medically necessary contact lenses. The allowance and your cost-sharing, if any, are listed in the Medical Benefits Chart "Vision care, Prescription eyewear" section. If the covered eyewear item you purchase costs more than the allowance for that item, you pay the difference. We will not provide the allowance if we have previously covered an eyewear item under this rider within the same allowance period.

The date we cover any of these prescription eyewear items is the date on which you order the item. If you order the item while you are covered under this **EOC**, and if we would otherwise cover the item, we will cover the prescription eyewear item even if you do not receive it until after you are no longer covered under this **EOC**.

If a network provider determines that one or both of your eyes has had a change in prescription of at least .50 diopters within 12 months after the date of your last exam where the "Prescription Eyewear Rider" benefit was used, we will provide an allowance toward the price of a replacement eyeglass lens or contact lens for each qualifying eye at the following maximum values:

- $60 for single vision eyeglass lenses.
- $60 for single vision contact lenses.
- $90 for multifocal eyeglass lenses.
- $90 for multifocal contact lenses.

This replacement lens allowance is the same total amount whether you replace one lens or two. The replacement lenses must be the same type as the lenses you are replacing (eyeglass lenses or contact lenses).

Medically necessary contact lenses

Contact lenses may be determined to be medically necessary and appropriate in the treatment of the following conditions:

- Keratoconus.
- Pathological myopia.
- Aphakia.

- Anisometropia.
- Aniseikonia.
- Aniridia.
- Corneal disorders.
- Post-traumatic disorders.
- Irregular astigmatism.

Prescription eyewear rider exclusions

- Low vision aids.
- Non-prescription products (other than eyeglass frames), such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.
- Non-prescription sunglasses.
- Optometric vision therapy and orthoptics (eye exercises).
- Plano contact lenses or glasses (non-prescription).
- Professional services for evaluation, fitting and follow-up care for contact lenses, except that this exclusion does not apply to medically necessary contact lenses.
- Replacement of lost, broken, or damaged lenses or frames.

KAISER PERMANENTE
Kaiser Foundation Health Plan
of the Northwest
500 NE Multnomah St., Ste 100
Portland, OR 97232

906**********SINGLE PIECE

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TAMI MAHRT
MULTNOMAH COUNTY EMPLOYEES
501 SE HAWTHORNE BLVD STE 400
EMPLOYEE BENEFITS
PORTLAND OR 97214-3586