January 1 – December 31, 2022

Evidence of Coverage

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Kaiser Permanente Senior Advantage (HMO) for Federal Members Fresno Area

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 to December 31, 2022. It explains how to get coverage for the health care services and prescription drugs you need. This is an important legal document. Please keep it in a safe place.

This plan, Kaiser Permanente Senior Advantage, is offered by Kaiser Foundation Health Plan, Inc., Northern California Region (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 for free in Spanish. Please contact our Member Services number at **1-800-443-0815** for additional information. (TTY users should call **711**.) Hours are 8 a.m. to 8 p.m., 7 days a week.

Este documento está disponible de forma gratuita en español. Si desea información adicional, por favor llame al número de nuestro Servicio a los Miembros al **1-800-443-0815**. (Los usuarios de la línea TTY deben llamar al **711**). El horario es de 8 a.m. a 8 p.m., siete días a la semana.

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

Benefits and/or copayments/coinsurance may change on January 1, 2023. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

CA22_FEHB_FRESNOEOC
OMB Approval 0938-1051 (Expires: December 31, 2022)

KAISER PERMANENTE®

2022 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. You will find a detailed list of topics at the beginning of each chapter.

Chapter 1 — Getting started as a member

Section 1 — Introduction

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

You are covered by Medicare and enrolled in Kaiser Permanente through the Federal Employees Health Benefits (FEHB) Program, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Kaiser Permanente Senior Advantage.

There are different types of Medicare health plans. 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 booklet about?

This **Evidence of Coverage** booklet tells you how to get your Medicare medical care and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of our plan.

This **Evidence of Coverage** describes more than one Senior Advantage plan for Federal Members in our Northern California Region's Fresno service area and they all include Medicare Part D prescription drug coverage:

- **High Option Senior Advantage 1 plan**
- **High Option Senior Advantage 2 plan**
- **Standard Option Senior Advantage plan**

If you are not certain which plan you are enrolled in, please call Member Services.

In order to receive the benefits described in this booklet, you must be enrolled in Kaiser Permanente through the Federal Employee Health Benefits (FEHB) Program and meet the eligibility requirements described in your FEHB brochure (RI 73-889). As a member of Kaiser Permanente Senior Advantage, you are still entitled to coverage under the FEHB Program. For a complete statement of your FEHB benefits, including any limitations and exclusions, please refer to your FEHB brochure (RI 73-889). All FEHB benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB brochure.

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** booklet.

If you are confused or concerned or just have a question, please contact Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.3 – Legal information about the Evidence of Coverage

This **Evidence of Coverage** explains what we cover in addition to your enrollment form, our **2022 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."

The **Evidence of Coverage** is in effect for the months in which you are enrolled in Senior Advantage between January 1, 2022, and December 31, 2022, unless amended.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue to get Medicare coverage as a member of our plan as long as 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 all of the following are true:

- You have both Medicare Part A and Medicare Part B (or Part B only) (Section 2.2 below tells you about Medicare Part A and Medicare Part B).
- You live in our geographic service area (Section 2.3 below describes our service area).
- You are a United States citizen or are lawfully present in the United States.

Section 2.2 – What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services), skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services (such as physician's services, home infusion therapy, and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 – Here is our plan service area for Senior Advantage

Although Medicare is a federal program, 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 for this plan includes these parts of counties in California, in the **following ZIP codes only**:

- **Fresno County**: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12,

93714–18, 93720–30, 93737, 93740–41, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–79, 93786, 93790–94, 93844, and 93888.

- **Kings County**: 93230, 93232, 93242, 93631, and 93656.
- **Madera County**: 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, and 93720.
- **Mariposa County**: 93601, 93623, and 93653.
- **Tulare County**: 93238, 93261, 93618, 93631, 93646, 93654, 93666, and 93673.

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

Note: Subject to approval by the Centers for Medicare & Medicaid Services, we may reduce or expand our service area effective any January 1. ZIP codes are subject to change by the U.S. Postal Service.

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet).

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 2.4 – 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 2.5 – Group eligibility requirements

You must be enrolled in Kaiser Permanente through the FEHB Program and meet the eligibility requirements described in your FEHB brochure (RI 73-889). For a complete statement of your benefits under the FEHB Program, including any limitations and exclusions, please read the FEHB brochure. All FEHB Program benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB brochure.

Section 2.6 – When you can enroll and when coverage begins

You can enroll at any time. After we receive your completed Senior Advantage Election Form, we will submit your enrollment request to the Centers for Medicare & Medicaid Services for confirmation and send you a notice indicating the proposed effective date of your Senior Advantage coverage under this **Evidence of Coverage**.

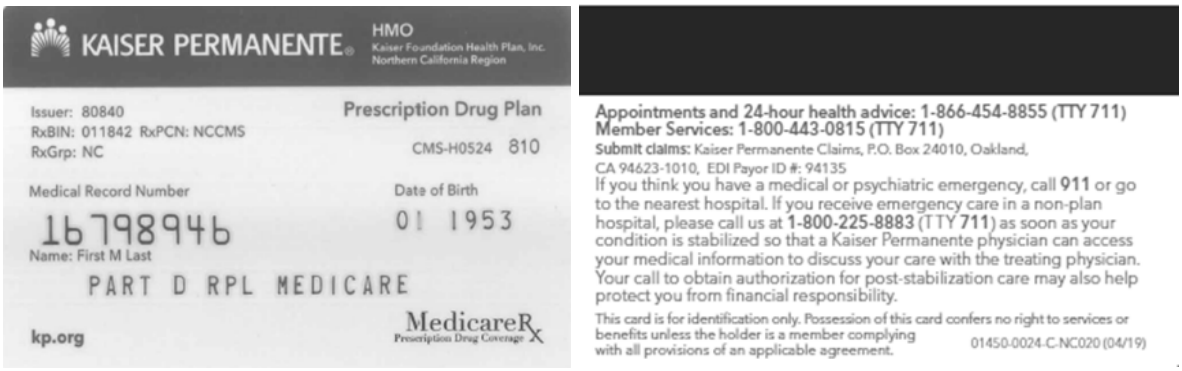
If the Centers for Medicare & Medicaid Services confirms your Senior Advantage enrollment and effective date, we will send you a notice that confirms your enrollment and effective date. If the Centers for Medicare & Medicaid Services tells us that you do not have Medicare Part B coverage, we will notify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

Note: If you are a subscriber under this **Evidence of Coverage** and 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 coverage offered through the FEHB Program.

Section 3 — What other materials will you get from us?

Section 3.1 – Your plan membership card—use it to get all covered care and prescription drugs

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

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your Senior Advantage membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. Phone numbers for Member Services are printed on the back cover of this booklet.

Section 3.2 – The Provider Directory: Your guide to all providers in our network

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

What are "network providers"?

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. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and suppliers is available on our website at **kp.org/directory**.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, care covered under our travel benefit, and cases in which our plan authorizes use of out-of-network providers. See Chapter 3, "Using our plan's coverage for your medical services," for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the **Provider Directory**, you can request a copy from Member Services (phone numbers are printed on the back cover of this booklet). You may ask Member Services for more information about our network providers, including their qualifications. You can view or download the **Provider Directory** at **kp.org/directory**. Both Member Services and our website can give you the most up-to-date information about our network providers.

Section 3.3 – The Pharmacy Directory: Your guide to pharmacies in our network

What are "network pharmacies"?

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the **Pharmacy Directory** to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. An updated **Pharmacy Directory** is located on our website at **kp.org/directory**. You may also call Member Services for updated provider information or to ask us to mail you a **Pharmacy Directory**. Please review the 2022 Pharmacy Directory to see which pharmacies are in our network.

If you don't have the **Pharmacy Directory**, you can get a copy from Member Services (phone numbers are printed on the back cover of this booklet). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. 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 **2022 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 (phone numbers are printed on the back cover of this booklet).

Section 3.5 – The Part D Explanation of Benefits (the "Part D EOB"): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the **Part D Explanation of Benefits** (or the **"Part D EOB").**

The **Part D EOB** tells you the total amount you, others on your behalf, and we have spent on your Part D prescription drugs and the total amount paid for each of your Part D prescription drugs during each month the Part D benefit is used. The **Part D EOB** provides more information about the drugs you take, such as increases in price and other drugs with lower cost-sharing that may be available. You should consult with your prescriber about these lower cost options. Chapter 6, "What you pay for your Part D prescription drugs," gives you more information about the **Part D EOB** and how it can help you keep track of your drug coverage.

The **Part D EOB** is also available upon request. To get a copy, please contact Member Services (phone numbers are printed on the back cover of this booklet). 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.

Section 4 — Premiums

Section 4.1 – Plan and Medicare premiums

Plan premiums

To receive benefits for this Senior Advantage plan, you must continue to pay your regular FEHB Program contributions (described in the FEHB brochure). There is no increase in your FEHB Program contributions for Senior Advantage membership.

Section 5 — Do you have to pay the Part D "late enrollment penalty"?

Section 5.1 – What is the Part D "late enrollment penalty"?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty.

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a Part D late enrollment penalty if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The cost of the late enrollment penalty depends upon 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.

We will inform you if you are required to pay a late enrollment penalty.

Section 5.2 – How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't 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 2022, this average premium amount is $33.37.
- 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 $33.37, which equals $4.67. This rounds to $4.70. 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. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- 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.

Section 5.3 – In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the Part D late enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "creditable drug coverage." **Please note:**
  - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the 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. **Please note:** If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must

state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.

- ♦ The following are not creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
- ♦ For additional information about creditable coverage, please look in your **Medicare & You** 2022 handbook or call Medicare at **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.

- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

Section 5.4 – What can you do if you disagree about your Part D late enrollment penalty?

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. 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. Call Member Services to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

Section 6 — Do you have to pay an extra Part D amount because of your income?

Section 6.1 – Who pays an extra Part D amount because of income?

If your modified adjusted gross income as reported on your IRS tax return from two years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium.

If you have to pay an extra amount, Social Security, not our plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, 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. **You must pay the extra amount to the government.**

Section 6.2 – How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your other Medicare premium. For more information on the extra amount you may have to pay based on your income, visit **www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html.**

Section 6.3 – What can you do if you disagree about paying an extra Part D amount?

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

Section 6.4 – What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required by law to pay the extra amount and you do not pay it, you will be disenrolled from Senior Advantage and lose Part D prescription drug coverage.

Section 7 — More information about your monthly premium

Many members are required to pay other Medicare premiums

Many members are required to pay other Medicare premiums. As explained in Section 2 of this chapter, in order to be eligible for our plan, you must have both Medicare Part A and Medicare Part B (or Medicare Part B only). Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members pay a premium for Medicare Part B. You must continue paying your Medicare premiums to remain a member of our plan.

If your modified adjusted gross income as reported on your IRS tax return from two years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from our plan and lose prescription drug coverage.**
- If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to Section 6 of this chapter. You can also visit **www.medicare.gov** on the Web or call **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 may call Social Security at **1-800-772-1213**. TTY users should call **1-800-325-0778**.

Your copy of the **Medicare & You** 2022 handbook gives you information about Medicare premiums in the section called "2022 Medicare Costs." This explains how Medicare premiums differ for people with different incomes. Everyone with Medicare receives a copy of the **Medicare & You** 2022 handbook each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of the **Medicare & You** 2022 handbook from the Medicare website (**www.medicare.gov**). Or, you can order a printed copy by phone at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**.

Section 8 — Please keep your plan membership record up-to-date

Section 8.1 – How to help make sure that we have accurate information about you

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.

If any of this information changes, please let us know by calling Member Services (phone numbers are printed on the back cover of this booklet).

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.

Read over the information we send you about any other insurance coverage you have

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. (For more information about how our coverage works when you have other insurance, see Section 10 in this chapter.)

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 (phone numbers are printed on the back cover of this booklet).

Section 9 — We protect the privacy of your personal health information

Section 9.1 – We make sure that your health information is protected

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.

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.3, of this booklet.

Section 10 — How other insurance works with our plan

Section 10.1 – Which plan pays first when you have other insurance?

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.

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 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.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are printed on the back cover of this booklet). 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.

Chapter 2 — Important phone numbers and resources

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

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

How to contact us when you are asking for a coverage decision or making an appeal or complaint 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. An appeal is a formal way of asking us to review and change a coverage decision we have made.

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

For more information about asking for coverage decisions or making appeals or complaints about your medical care, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." You may call us if you have questions about our coverage decision, appeal, or complaint processes.

METHOD	Coverage decisions, appeals, or complaints about medical care – contact information
CALL	**1-800-443-0815** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.

METHOD	Coverage decisions, appeals, or complaints about medical care – contact information
	If your coverage decision, appeal, or complaint qualifies for a fast decision as described in Chapter 9, call the Expedited Review Unit at **1-888-987-7247**, 8:30 a.m. to 5 p.m., Monday through Saturday.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
FAX	If your coverage decision, appeal, or complaint qualifies for a fast decision, fax your request to our Expedited Review Unit at **1-888-987-2252**.
WRITE	For a standard coverage decision or complaint, write to your local Member Services office (see the Provider Directory for locations). For a standard appeal, write to the address shown on the denial notice we send you. If your coverage decision, appeal, or complaint qualifies for a fast decision, write to: Kaiser Permanente Expedited Review Unit P.O. Box 1809 Pleasanton, CA 94566
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to **www.medicare.gov/MedicareComplaintForm/home.aspx.**

How to 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	**1-877-645-1282** 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 for Part D prescription drugs – contact information
FAX	**1-844-403-1028**
WRITE	OptumRx c/o Prior Authorization P.O. Box 25183 Santa Ana, CA 92799
WEBSITE	**kp.org**

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

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information about making appeals about your Part D prescription drugs, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." You may call us if you have questions about our appeals processes.

METHOD	Appeals for Part D prescription drugs – contact information
CALL	**1-866-206-2973** Calls to this number are free. Monday through Friday, 8:30 a.m. to 5 p.m.
TTY	**711** Calls to this number are free. Monday through Friday, 8 a.m. to 8 p.m.
FAX	**1-866-206-2974**
WRITE	Kaiser Permanente CA Medicare PDU/MSU Operations P.O. Box 1809 Pleasanton, CA 94566
WEBSITE	**kp.org**

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

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about our plan's coverage or payment, you should look at the section above about requesting coverage decisions or making an appeal.) For more information about making a complaint 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	Complaints about Part D prescription drugs – contact information
CALL	**1-800-443-0815** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. If your complaint qualifies for a fast decision, call the Part D Unit at **1-866-206-2973**, 8:30 a.m. to 5 p.m., Monday through Friday. See Chapter 9 to find out if your issue qualifies for a fast decision.
TTY	**711** Calls to this number are free. Monday through Friday, 8 a.m. to 8 p.m.
FAX	If your complaint qualifies for a fast decision, fax your request to our Part D Unit at **1-866-206-2974**.
WRITE	For a standard complaint, write to your local Member Services office (see the **Provider Directory** for locations). If your complaint qualifies for a fast decision, write to: Kaiser Permanente CA Medicare PDU/MSU Operations P.O. Box 1809 Pleasanton, CA 94566
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to **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

For more information about situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see 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	**1-800-443-0815** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Note: If you are requesting payment of a Part D drug that was prescribed by a network provider and obtained from a network pharmacy, call our Part D Unit at **1-866-206-2973**. 8:30 a.m. to 5 p.m., Monday through Friday.

METHOD	Payment requests – contact information
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	For medical care, write to: Kaiser Permanente Claims Department P.O. Box 12923 Oakland, CA 94604-2923 For Part D drugs, write to: If you are requesting payment of a Part D drug that was prescribed and provided by a network provider, you can fax your request to **1-866-206-2974** or mail it to: Kaiser Permanente CA Medicare PDU/MSU Operations P.O. Box 1809 Pleasanton, CA 94566
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**

METHOD	Medicare – contact information
	This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options, with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about our plan: • **Tell Medicare about your complaint:** You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to **www.medicare.gov/MedicareComplaintForm/home.aspx.** Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 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. In California, the SHIP is called the Health Insurance Counseling and Advocacy Program (HICAP).

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

HICAP counselors can help you with your Medicare questions or problems. They 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. HICAP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Method to access SHIP and other resources:

- Visit **www.medicare.gov.**
- Click on "**Forms, Help, and Resources**" on far right of menu on top.
- In the drop down, click on "**Phone Numbers & Websites.**"
- You now have several options:
  - Option 1: You can have a live chat.
  - Option 2: You can click on any of the "Topics" in the menu on bottom.
  - Option 3: You can select your state from the dropdown menu and click "Go." This will take you to a page with phone numbers and resources specific to your state.

METHOD	Health Insurance Counseling and Advocacy Program (California's SHIP) – contact information
CALL	**1-800-434-0222**
TTY	**711**
WRITE	Your HICAP office for your county.
WEBSITE	**www.aging.ca.gov/HICAP/**

Section 4 — Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

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

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

You should contact Livanta in any of these situations:

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

METHOD	Livanta (California's Quality Improvement Organization) – contact information
CALL	**1-877-588-1123** Calls to this number are free. Monday through Friday, 9 a.m. to 5 p.m. Weekends and holidays 11 a.m. to 3 p.m.
TTY	**1-855-887-6668** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
WEBSITE	**www.livantaqio.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 7 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**

METHOD	Social Security – contact information
	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 7 a.m. to 7 p.m., Monday through Friday.
WEBSITE	**www.ssa.gov**

Section 6 — Medicaid (a joint federal and state program that helps with medical costs for some people with limited income and resources)

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

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

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

METHOD	Medi-Cal (California's Medicaid program) – contact information
CALL	**1-800-541-5555** Calls to this number are free. Monday through Friday, 8 a.m. to 8 p.m.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	California Department of Health Care Services P.O. Box 997417, MS 4607 Sacramento, CA 95899-7417
WEBSITE	**http://www.cdss.ca.gov/**

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

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.

Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

You may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, 24 hours a day/7 days a week;
- The Social Security Office at **1-800-772-1213**, between 7 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 established a process that allows you 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 payment directly to the state. Please contact Member Services if you have questions (phone numbers are printed on the back cover of this booklet).

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program is available nationwide. Because our plan does not have a coverage gap the discounts described here do not apply to you. Instead, our plan continues to cover your drugs at your regular cost-sharing amount until you qualify for the Catastrophic Coverage Stage. Please go to Chapter 6, Section 5, for more information about your coverage during the Initial Coverage Stage.

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 covered by ADAP qualify for prescription cost-sharing assistance through the California AIDS Drug Assistance Program. 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 are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number through the ADAP call center at **1-844-421-7050** between 8 a.m. and 5 p.m., Monday through Friday (excluding holidays).

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP call center at **1-844-421-7050** between 8 a.m. and 5 p.m. (excluding holidays).

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 have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

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

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/**

Chapter 3 — Using our plan's coverage for your medical services

Section 1 — Things to know about getting your medical care covered 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, 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 in the next chapter, Chapter 4, "Medical Benefits Chart (what is covered and what you pay)."

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

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"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, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

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** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered 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 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. Here are four 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 and the providers in our network cannot provide this care, you can get this care from an out-of-network provider 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 2.3 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.
  - Care you receive from network providers in other Kaiser Permanente regions described in Section 2.4 in this chapter.
  - Care covered under our travel benefit as described in the Medical Benefits Chart.

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) and sometimes obstetrics/gynecology. At some network facilities, if you prefer, you may choose an available nurse practitioner or physician assistant to be your primary care provider. PCPs are identified in the **Provider Directory**.

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

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

When you call, tell us if you 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 getting approval in advance 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 from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible (for example, when you are temporarily outside of our service area).
- 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.) Phone numbers for Member Services are printed on the back cover of this booklet.
- Second opinions from another network provider except for certain specialty care.
- Appointments in the following areas: optometry, substance abuse, and psychiatry.
- Preventive care except for abdominal aortic aneurysm screenings, medical nutritional therapy, flexible sigmoidoscopy, screening colonoscopy, bone density screening, and lab tests.

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

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. 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, your network provider will need to get approval in advance from our plan or Medical Group (this is called getting "prior authorization"). Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals. If you ever disagree with authorization decisions, you can file an appeal as described in Chapter 9.

- Services and items identified in Chapter 4 with a footnote (†).
- If your network provider decides that you require covered services not available from network providers, he or she will recommend to Medical Group that you be referred to an out-of-network provider inside or outside our service area. The appropriate Medical Group designee will authorize the services if he or she determines that the covered services are medically necessary and 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.
- 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 evaluation, Medical Group's regional transplant advisory committee or board or case conference (if one exists) will authorize the referral if it determines that you are a potential candidate for organ transplant and the service is covered in accord with Medicare guidelines. In cases where no transplant committee or board exists, Medical Group will refer you to physician(s) at a transplant center, and Medical Group will authorize the services if the transplant center's physician(s) determine that they are medically necessary or covered in accord with Medicare guidelines. Note: A network physician may provide or authorize a corneal transplant without using this Medical Group transplant authorization procedure.

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. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave 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 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 an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us at **1-800-443-0815** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m., so we can assist you in finding a new provider to manage your care.

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.

Section 3 — How to get covered 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 loss of life, 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.

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.
- **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?

You may get covered emergency medical care whenever you need it, anywhere inside or outside the United States. We cover ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

You may get covered emergency medical care (including ambulance) when you need it anywhere in the world. However, you may have to pay for the services and file a claim for reimbursement (see Chapter 7 for more information).

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. We will cover your follow-up post-stabilization care in accord with Medicare guidelines. 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. 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.

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 these urgently needed services (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"?

"Urgently needed services" are a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in our service area when you have an urgent need for care?

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible, and it is not reasonable to wait to obtain

care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

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.

What if you are outside our service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, we will cover urgently needed services that you get from any provider. Our plan covers worldwide 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.

Generally, if you cannot use a network provider during a disaster, we 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 covered 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 share 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 medical services that are medically necessary, are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services or they were obtained out-of-network and were not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services to get more information (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you 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. You can call Member Services when you want to know how much of your benefit limit you have already used.

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. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. 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.

Once Medicare approves the study, 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. 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 a Medicare-approved clinical research study, you do not need 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, you do need to tell us before you start participating in a clinical research study.

If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what we will pay.

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

Once you join a Medicare-approved clinical research study, you are covered for 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.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs:

- We will pay the difference between the cost-sharing in Original Medicare and your 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.
  - 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 we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.
- In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.
- In addition, your FEHB plan covers routine costs and may cover some extra care not provided by a clinical trial. Refer to your FEHB brochure (RI 73-889).

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 and services the study gives you or any participant for free.
- 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.
- Items and services provided solely to determine trial eligibility.

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 covered in a "religious nonmedical health care institution"

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

A religious nonmedical 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 nonmedical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (nonmedical health care services). Medicare will only pay for nonmedical health care services provided by religious nonmedical health care institutions.

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, you will not acquire ownership no matter how many copayments you make for the item while a member of 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. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare before you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

Section 8 Rules for oxygen equipment, supplies, and maintenance

Section 8.1 – What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, 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 to the owner.

Section 8.2 – What is your cost sharing? Will it change after 36 months?

Your cost-sharing for Medicare oxygen equipment coverage is **20%** coinsurance, every time you receive equipment.

Your cost-sharing will not change after being enrolled for 36 months in our plan.

If prior to enrolling in our plan, you had made 36 months of rental payment for oxygen equipment coverage, your cost-sharing in our plan is 20% coinsurance.

Section 8.3 – What happens if you leave your plan and return to Original Medicare?

If you return to Original Medicare, then you start a new 36-month cycle that renews every five years. For example, if you had paid rentals for oxygen equipment for 36 months prior to joining our plan, join our plan for 12 months, and then return to Original Medicare, you will pay full cost-sharing for oxygen equipment coverage.

Similarly, if you made payments for 36 months while enrolled in our plan and then return to Original Medicare, you will pay full cost-sharing for oxygen equipment coverage.

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

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

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a 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. 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 Chapters 3, 11, and 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). Also in this chapter, please see Section 2.2 for additional chiropractic coverage, Section 2.3 for the fitness benefit for members enrolled in the High Option Senior Advantage 2 plan, or Section 2.4 for additional dental coverage from DeltaCare USA for members enrolled in the High Option Senior Advantage 1 or Standard Option Senior Advantage plans.

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 in Section 2 of this Chapter 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 in Section 2 of this Chapter tells you more about your coinsurance.)

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

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Member Services.

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 to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B (see the Medical Benefits Chart in Section 2 below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of our plan, the most you will have to pay out-of-pocket for in-network covered Part A and Part B services and Part D prescription drugs in 2022 is **$2,000 for any one member**. The 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 of **$2,000 for any one member**, 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 and Part D prescription drugs. 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. 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. 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.)
  - 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.)
- If you believe a provider has "balance billed" you, call Member Services (phone numbers are printed on the back cover of this booklet).

Section 2 — Use this Medical Benefits Chart to find out what is covered for you and how much you will pay

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

The Medical Benefits Chart on the following pages lists the services we cover and what you pay out-of-pocket for each service. 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, and equipment) 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. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- 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." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart 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 Section 2.2 in this chapter and 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** 2022 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.

- Sometimes Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2022, either Medicare or our plan will cover those services.

The Medical Benefits Chart below describes the medical benefits of the following Kaiser Permanente Senior Advantage plans for Federal Members in our Northern California Region's Fresno service area included in this **Evidence of Coverage**:

- High Option Senior Advantage 1 plan.
- High Option Senior Advantage 2 plan.
- Standard Option Senior Advantage plan.

If you are not certain which plan you are enrolled in, please call Member Services.

Additional FEHB coverage

The FEHB brochure includes non-FEHB benefits not discussed in this **Evidence of Coverage**. For a complete statement of your benefits under the FEHB Program, including any limitations and exclusions, please read your FEHB brochure (RI 73-889). All FEHB Program benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB brochure.

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
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, etc. disease). 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. 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:	You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan. • **$15** for members of the Standard Option Senior Advantage plan.

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

Services that are covered for you	What you must pay when you get these services
• A master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • A current, full, active, and unrestricted license to practice acupuncture in a state, territory, or commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by regulations at 42 CFR §§ 410.26 and 410.27.	
Acupuncture not covered by Medicare† Acupuncture typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.	You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan. • **$15** for members of the Standard Option Senior Advantage plan.
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	You pay the following per one-way trip, depending upon the plan in which you are enrolled: • **$50** for members of the High Option Senior Advantage 1 or High Option Senior Advantage 2 plans. • **$125** for members of the Standard Option Senior Advantage plan.

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

Services that are covered for you	What you must pay when you get these services
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. Also, for members on the High Option Senior Advantage 1 plan, please refer to "Transportation services" in this Medical Benefits Chart for additional transportation coverage we cover that is separate from the services described here.	
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.
Bariatric surgery We cover hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, other diagnostic and treatment services, and plan physician services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:	For covered Services related to bariatric surgical procedures that you receive, you will pay the **copayment or coinsurance you would pay if the services were not related to a bariatric surgical procedure**. For example, see "Inpatient Hospital Care" in this

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

Services that are covered for you	What you must pay when you get these services
• You complete the medical group–approved, pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success. • A plan physician who is a specialist in bariatric care determines that the surgery is medically necessary.	Medical Benefits Chart for the copayment or coinsurance that applies for hospital inpatient care.
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 medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39. • One screening mammogram every 12 months for women age 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.	You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan. • **$15** for members of the Standard Option Senior Advantage plan.

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

Services that are covered for you	What you must pay when you get these services
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.
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 provider or a chiropractor when referred by a network provider.	You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan. • **$15** for members of the Standard Option Senior Advantage plan.
Also, please refer to Section 2.2 for a description of your additional chiropractic services we cover that are separate from the services described here.	

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

Services that are covered for you	What you must pay when you get these services
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: ○ Guaiac-based fecal occult blood test (gFOBT). ○ 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**
Dental and orthodontic services for cleft palate†* We cover dental extractions, dental procedures necessary to prepare the mouth for an extraction and orthodontic services, if they meet all of the following requirements: • The services are an integral part of reconstructive surgery for cleft palate ("cleft palate" includes cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate). • A plan provider provides the services, or the Medical Group authorizes a referral to a non-plan provider who is a dentist or orthodontist.	**Office visits** You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan. • **$15** for members of the Standard Option Senior Advantage plan.

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

Services that are covered for you	What you must pay when you get these services
	Outpatient surgery You pay the following per procedure, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$15** for members of the Standard Option Senior Advantage plan. • **$50** for members of the High Option Senior Advantage 2 plan. **Inpatient care** You pay the following**,** depending upon the plan in which you are enrolled: • **$0** for members of the High Option Senior Advantage 1 plan. • **$250 per admission** for members of the High Option Senior Advantage 2 or Standard Option Senior Advantage plans.
Dental services for radiation treatment, dental anesthesia, pre-transplant, and accidental injury to teeth† **Dental Services for radiation treatment** We cover services in accord with Medicare guidelines, including dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck if a plan physician provides the services or if the Medical Group authorizes a referral to a dentist. **Dental anesthesia** For dental procedures at a plan facility, we provide general anesthesia and the facility's services associated with the anesthesia if all of the following are true:	**Office visits** You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan.

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

Services that are covered for you	What you must pay when you get these services
• You are under age 7, or you are developmentally disabled, or your health is compromised. • Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center. • The dental procedure would not ordinarily require general anesthesia. We do not cover any other services related to the dental procedure, such as the dentist's services, except for services covered under "Dental and orthodontic services for cleft palate" and "Accidental injury to teeth," or if covered in accord with Medicare guidelines.	• **$15** for members of the Standard Option Senior Advantage plan. **Outpatient surgery** You pay the following per procedure, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$15** for members of the Standard Option Senior Advantage plan**.** • **$50** for members of the High Option Senior Advantage 2 plan. **Inpatient care** You pay the following**,** depending upon the plan in which you are enrolled: • **$0** for members of the High Option Senior Advantage 1 plan. • **$250 per admission** for members of the High Option Senior Advantage 2 or Standard Option Senior Advantage plans.
Pre-transplant We cover dental services necessary to ensure the oral cavity is clear of infection prior to being placed on the transplant wait list for allogeneic stem cell/bone marrow, heart, kidney, liver, lung, pancreas, and multiple-organ transplants. In the case of urgent transplantation, these services may be performed post-transplant. Services include: • Examination and evaluation of the oral cavity. • Treatment services including extractions necessary for the transplant.	**Office visits** You pay the following per primary visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan.

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

Services that are covered for you	What you must pay when you get these services
• Relevant dental X-rays. • Cleaning. • Fluoride treatments.	• **$15** for members of the Standard Option Senior Advantage plan. **X-rays** You pay the following per encounter, depending upon the plan in which you are enrolled: • **$0** for members of the High Option Senior Advantage 1 or High Option Senior Advantage 2 plans. • **$10** for members of the Standard Option Senior Advantage plan.
Accidental injury to teeth* We cover services to promptly repair (but not replace) a sound, natural tooth, if: • Damage is due to an accidental injury from trauma to the mouth from violent contact with an external object, • The tooth has not been restored previously, except in a proper manner, and • The tooth has not been weakened by decay, periodontal disease, or other existing dental pathology. **Note:** Services will be covered only when provided within 72 hours following the accidental injury. **Not covered:** Services for conditions caused by an accidental injury occurring before your eligibility date.	**No charge** up to the benefit maximum of **$500** of covered charges per accidental injury. You pay all charges after reaching the benefit maximum.
Also, for members of the High Option Senior Advantage 1 and Standard Option Senior Advantage plans, please refer to Section 2.4 for a description of your additional dental coverage provided to you as a Senior Advantage Federal Member.	

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

Services that are covered for you	What you must pay when you get these services
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 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training and 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. • †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. Diabetes self-management training is covered under certain conditions. †Note: You may choose to receive diabetes self-management training from a program outside our plan that is recognized by the American Diabetes Association and approved by Medicare.	**$0**

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

Services that are covered for you	What you must pay when you get these services
Durable medical equipment (DME) and related supplies† (For a definition of "durable medical equipment," see Chapter 12 of this booklet.) 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, walkers, and external sexual dysfunction devices. 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 can special order it for you. The most recent list of suppliers is available on our website at **kp.org/directory**. We also cover the following DME not covered by Medicare when medically necessary: • Bed accessories for a hospital bed when bed extension is required. • Heel or elbow protectors to prevent or minimize advanced pressure relief equipment use. • Iontophoresis device to treat hyperhidrosis when antiperspirants are contraindicated and the hyperhidrosis has created medical complications (for example skin infection) or is preventing daily living activities. • Nontherapeutic continuous glucose monitoring devices and related supplies. • Resuscitation bag if tracheostomy patient has significant secretion management problems, needing lavage and suction technique aided by deep breathing via resuscitation bag. • Ultraviolet light therapy equipment for conditions other than psoriasis as medically necessary.	**20%** coinsurance, except you pay **$0** for peak flow meters and ultraviolet light therapy equipment.

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

Services that are covered for you	What you must pay when you get these services
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, 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.**	**$75** Emergency Department visit. This copayment does not apply if you are admitted directly to the hospital as an inpatient within 24 hours (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.
Health and wellness education programs As part of our Healthy Lifestyle Programs, our plan covers a number of group health education classes including: healthy heart, living with chronic conditions and depression. The Healthy Lifestyle Programs are provided by a certified health educator or other qualified health professional. We also cover a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for chronic conditions (such as diabetes and asthma). You can also participate in programs that we don't cover, which may require that you pay a fee. For more information about our health education counseling, programs, and materials, please contact your local Health Education Department, call Member Services or go to our website at **kp.org**.	**$0**

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

Services that are covered for you	What you must pay when you get these services
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.	You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan. • **$15** for members of the Standard Option Senior Advantage plan.
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 every 12 months. • For women who are pregnant, we cover up to three screening exams during a pregnancy.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home-delivered meals We cover meals delivered to your home as follows: • As part of the discharge process, someone from your care team will initiate a referral valid for 30 days. Once the referral is approved, the meal delivery vendor will contact you with meal options and arrange meal delivery (unused referrals are not renewable). • In addition to meals for general health, there are menus to support specific conditions and diets.	High Option Senior Advantage 1 plan: • **$0** up to **three** meals per day in a consecutive four-week period, once per calendar year, immediately following discharge from a hospital or skilled nursing facility as an inpatient. High Option Senior Advantage 2 or Standard Option Senior Advantage plans: • **$0** up to **two** meals per day in a consecutive four-week period, once per calendar year, immediately following discharge from a hospital as an inpatient due to congestive heart failure.

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

Services that are covered for you	What you must pay when you get these services
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: • Physical therapy, occupational therapy, and speech therapy. • Medical and social services. • Medical equipment and supplies. †The Medical Group must authorize any home health nursing or other care of at least eight continuous hours (authorization procedure does not apply to home health nursing or other care of less than eight continuous hours).	**$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. • Remote monitoring. • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	**$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.
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.	**$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

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Services that are covered for you	What you must pay when you get these services
• Your prescription is written by a network provider and filled at a network home-infusion pharmacy.	elsewhere in this booklet depending on the service.
Hospice care for members with Parts A & B You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief. • Short-term respite care. • Home care. ***For hospice services and services that are covered by Medicare Part A or B and are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. **For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:** If you need nonemergency, non–urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, 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	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan.

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

Services that are covered for you	What you must pay when you get these services
cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. **For drugs that may be covered by our plan's Part D benefit:** Drugs are never covered by both hospice and our plan at the same time. For more information, please see 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 (one time only) for a terminally ill person who hasn't elected the hospice benefit.	You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan. • **$15** for members of the Standard Option Senior Advantage plan.
Hospice care for Part B Only plan members The hospice benefit described above does not apply to Part B Only plan members. Our plan, rather than Original Medicare, covers hospice care for Part B Only plan members. We cover the hospice services listed below if all of the following requirements are met: • A network physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less. • The services are provided inside our service area (or inside California but within 15 miles or 30 minutes from our service area if you live outside our service area, and you have been a Senior Advantage member	**$0**

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

Services that are covered for you	What you must pay when you get these services
continuously since before January 1, 1999, at the same home address). • The services are provided by a licensed hospice agency that is a network provider. • A network physician determines that the services are necessary for the palliation and management of your terminal illness and related conditions. If all of the above requirements are met, we cover the following hospice services, if necessary for your hospice care: • Network physician services. • Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers. • Physical, occupational, or speech therapy for purposes of symptom control or to enable you to maintain activities of daily living. • Respiratory therapy. • Medical social services. • Home health aide and homemaker services. • Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from network pharmacies. Certain drugs are limited to a maximum 30-day supply in any 30-day period. • Durable medical equipment. • Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time. • Counseling and bereavement services. • Dietary counseling. • We also cover the following hospice services only during periods of crisis when they are medically necessary to achieve palliation or management of acute medical symptoms:	

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Services that are covered for you	What you must pay when you get these services
♦ Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home. ♦ Short-term inpatient care required at a level that cannot be provided at home.	
• We cover hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan. • **$15** for members of the Standard Option Senior Advantage plan.
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.	You pay the following, depending upon the plan in which you are enrolled: • **$0** for members of the High Option Senior Advantage 1 plan. • **$250 per admission** for members of the

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Services that are covered for you	What you must pay when you get these services
There is no limit to the number of medically necessary hospital days or services that are generally and customarily 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.	High Option Senior Advantage 2 or Standard Option Senior Advantage plans. †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.

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

Services that are covered for you	What you must pay when you get these services
• Physician services.	
Note: To be an "inpatient," your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you 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 mental health care Covered services include mental health care services that require a hospital stay.	You pay the following, depending upon the plan in which you are enrolled: • **$0** for members of the High Option Senior Advantage 1 plan. • **$250 per admission** for members of the High Option Senior Advantage 2 or Standard Option Senior Advantage plans.
Inpatient stay: Covered services received in a hospital or SNF during a noncovered inpatient stay† If you have exhausted your 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.
*Cost-sharing for these services or items doesn't apply to 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.
We also cover nutrition/dietary counseling with a network provider not related to diabetes or ESRD.	You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan.

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

Services that are covered for you	What you must pay when you get these services
	• **$15** for members of the Standard Option Senior Advantage plan.
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: • 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.	**Generic drugs** • For members of the High Option Senior Advantage 1 plan: ♦ **$10** for up to a 100-day supply at a network pharmacy or through our mail-order pharmacy. • For members of the High Option Senior Advantage 2 or Standard Option Senior Advantage plans: ♦ **$10** for up to a 30-day supply. ♦ **$20** for up to a 100-day supply through our mail-order pharmacy. ♦ **$30** for up to a 100-day supply at a network pharmacy. **Brand name drugs** • For members of the High Option Senior Advantage 1 plan: ♦ **$30** for up to a 100-day supply. • For members of the High Option Senior Advantage 2 or Standard Option Senior Advantage plans:

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

Services that are covered for you	What you must pay when you get these services
	♦ **$40** for up to a 30-day supply. ♦ **$80** for up to a 100-day supply through our mail-order pharmacy. ♦ **$120** for up to a 100-day supply at a network pharmacy.
• 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. • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Antigens. • Certain 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** for up to a 30-day supply.
Non-Medicare prescription drugs If a drug, supply, or supplement is not covered by Medicare Part B or D, we cover the following additional items in accord with our non–Part D drug formulary when prescribed by a plan physician or a dentist and obtained at a plan pharmacy or through our mail-order service. • Drugs for which a prescription is required by law that are not covered by Medicare Part B or D. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary applicable to non-Part D items. • Inhaler spacers needed to inhale covered drugs. • Contraceptive rings and contraceptive patches. • Disposable needles and syringes needed for injecting covered drugs, pen delivery devices, and visual aids	**Generic drugs** • For members of the High Option Senior Advantage 1 plan: ♦ **$10** for up to a 100-day supply at a network pharmacy or through our mail-order pharmacy. • For members of the High Option Senior Advantage 2 or Standard Option Senior Advantage plans: ♦ **$10** for up to a 30-day supply. ♦ **$20** for up to a 100-day supply through our mail-order pharmacy. ♦ **$30** for up to a 100-day supply at a network pharmacy.

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

Services that are covered for you	What you must pay when you get these services
required to ensure proper dosage (except eyewear), that are not covered by Medicare Part B or D. • Continuity non–Part D drugs: If this *EOC* is amended to exclude a non–Part D drug that we have been covering and providing to you under this *EOC*, we will continue to provide the non–Part D drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration (FDA).	**Brand name or specialty drugs** • For members of the High Option Senior Advantage 1 plan: ♦ **$30** for up to a 100-day supply at a network pharmacy or through our mail-order pharmacy. • For members of the High Option Senior Advantage 2 or Standard Option Senior Advantage plans: ♦ **$40** for up to a 30-day supply. ♦ **$80** for up to a 100-day supply through our mail-order pharmacy. ♦ **$120** for up to a 100-day supply at a network pharmacy.
• Prescription drugs approved by the FDA to treat tobacco dependence. • Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing.	**$0** for up to a 100-day supply.
• Amino acid-modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria) and elemental dietary enteral formula when used as a primary therapy for regional enteritis. • Certain self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as an intravenous or intraspinal-infusion). In addition, we cover the supplies and equipment required for the administration of these drugs.	**$0** for up to a 30-day supply.
Prescribed medications, including prescribed over-the-counter medications, required to be covered by group health plans at no cost share by federal health care reform (the Affordable Care Act and implementing regulations). These include:	**$0** for up to a 100-day supply.

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

Services that are covered for you	What you must pay when you get these services
• Aspirin to reduce the risk of heart attack. • Oral fluoride for children to reduce the risk of tooth decay. • Folic acid for women to reduce the risk of birth defects. • Vitamin D for adults to reduce the risk of falls. • Medication to reduce the risk of breast cancer.	
• Episodic drugs prescribed for the treatment of sexual dysfunction disorders up to a maximum of 8 doses in any 30-day period, up to 16 doses in any 60-day period, or up to 27 doses in any 100-day period.	**Generic drugs** • **25% coinsurance** (not to exceed **$50**) for up to a 100-day supply. **Brand-name drugs** • **25% coinsurance** (not to exceed **$100**) for up to a 100-day supply.
Non-Part D drug formulary. The non-Part D drug formulary includes a list of drugs that our Pharmacy and Therapeutics Committee has approved for our Members. Our Pharmacy and Therapeutics Committee, which is primarily composed of plan physicians, selects drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature. The Pharmacy and Therapeutics Committee meets at least quarterly to consider additions and deletions based on new information or drugs that become available. To find out which drugs are on the formulary for your plan, please visit our website at **kp.org/formulary**. If you would like to request a copy of the non–Part D drug formulary for your plan, please call our Member Service Contact Center. **Note:** The presence of a drug on the drug formulary does not necessarily mean that your plan physician will prescribe it for a particular medical condition. Drug formulary guidelines allow you to obtain nonformulary prescription drugs (those not listed on our drug formulary for your condition) if they would otherwise be covered and a plan physician determines that they are medically necessary. Also, our non-Part D formulary guidelines may require you to participate in a behavioral intervention program approved by the Medical Group for specific conditions and you may be required to pay for the program. **About specialty drugs.** Specialty drugs are high-cost drugs that are on our specialty drug list. If your plan physician prescribes more than a 30-day supply for an outpatient drug, you may be able to obtain more than a 30-day supply at one time, up to the day supply limit for that drug. However, most specialty drugs are limited to a 30-day supply in any 30-day period. Your plan pharmacy can tell you if a drug you take is one of these drugs.	

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

Services that are covered for you	What you must pay when you get these services
OTC exclusion. Prescription drugs for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the prescription drug) are excluded. This exclusion does not apply to: • Insulin. • Over-the-counter tobacco cessation drugs and contraceptive drugs. • An entire class of prescription drugs when one drug within that class becomes available over-the-counter. • Drugs covered by Medicare Parts B or D.	
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.	
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.	**$0**

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

Services that are covered for you	What you must pay when you get these services
• Periodic assessments.	
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays. • Ultrasounds. • All other laboratory tests. • Electrocardiograms (EKGs), holter monitoring, and electroencephalograms (EEGs). • Sleep studies.	You pay the following per encounter, depending upon the plan in which you are enrolled: • **$0** for members of the High Option Senior Advantage 1 or High Option Senior Advantage 2 plans. • **$10** for members of the Standard Option Senior Advantage plan.
• The following laboratory tests: ♦ A1c. ♦ Low-Density Lipoprotein (LDL). ♦ International Normalized Ratio (INR) for persons with liver disease or certain blood disorders. ♦ Glucose quantitative blood tests not covered at $0 under Original Medicare. • Radiation (radium and isotope) therapy, including technician materials and supplies. • Surgical supplies, such as dressings. • Splints, casts, and other devices used to reduce fractures and dislocations. Blood—including storage and administration.	**$0**
• Other outpatient diagnostic tests: ♦ Magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET).	You pay the following per procedure, depending upon the plan in which you are enrolled: • **$0** for members of the High Option Senior Advantage 1 or High Option Senior Advantage 2 plans. • **$50** for members of the Standard Option Senior Advantage plan.
♦ Any diagnostic test or special procedure that is provided in an outpatient department of a hospital	You pay the following per procedure, depending upon the plan in which you are enrolled:

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

Services that are covered for you	What you must pay when you get these services
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.	• **$5** for members of the High Option Senior Advantage 1 plan. • **$15** for members of the Standard Option Senior Advantage plan. • **$50** for members of the High Option Senior Advantage 2 plan.
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. **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.	**$75** 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.

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

Services that are covered for you	What you must pay when you get these services
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.	**Office visits** You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan. • **$15** for members of the Standard Option Senior Advantage plan. **Emergency Department** **$75** per visit. **Outpatient surgery** You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$15** for members of the Standard Option Senior Advantage plan. • **$50** for members of the High Option Senior Advantage 2 plan. Refer to the "Outpatient hospital observation" section of this Medical Benefits Chart for the cost-sharing applicable to observation services.

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

Services that are covered for you	What you must pay when you get these services
• The following laboratory tests billed by the hospital: ♦ A1c. ♦ Low-Density Lipoprotein (LDL). ♦ International Normalized Ratio (INR) for persons with liver disease or certain blood disorders. ♦ Glucose quantitative blood tests not covered at $0 under Original Medicare.	**$0**
• All other covered laboratory tests billed by the hospital. • Diagnostic tests billed by the hospital. • X-rays and other radiology services billed by the hospital.	You pay the following per encounter, depending upon the plan in which you are enrolled: • **$0** for members of the High Option Senior Advantage 1 or High Option Senior Advantage 2 plans. • **$10** for members of the Standard Option Senior Advantage plan. **MRI, CT, and PET** For magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET), you pay the following per procedure, depending upon the plan in which you are enrolled: • **$0** for members of the High Option Senior Advantage 1 or High Option Senior Advantage 2 plans. • **$50** for members of the Standard Option Senior Advantage plan.
• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it.	**$0** for partial hospitalization.
• Medical supplies such as splints and casts. • Certain drugs and biologicals that you can't give yourself.	**$0**

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

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 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.	You pay the following, depending upon the plan in which you are enrolled and the type of visit: • For members of the High Option Senior Advantage 1 plan: ♦ **$5** per individual therapy visit. ♦ **$2** per group therapy visit. • For members of the High Option Senior Advantage 2 plan: ♦ **$10** per individual therapy visit. ♦ **$5** per group therapy visit. • For members of the Standard Option Senior Advantage plan: ♦ **$15** per individual therapy visit. ♦ **$7** per group therapy visit.
• Mental health services in our intensive outpatient program.	**$0**
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,	You pay the following, depending upon the plan in which you are enrolled: • For members of the High Option Senior Advantage 1 plan:

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

Services that are covered for you	What you must pay when you get these services
independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	♦ **$5** per individual therapy visit. ♦ **$2** per group therapy visit. • For members of the High Option Senior Advantage 2 plan: ♦ **$10** per individual therapy visit. ♦ **$5** per group therapy visit. • For members of the Standard Option Senior Advantage plan: ♦ **$15** per individual therapy visit. ♦ **$7** per group therapy visit.
• Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program.	You pay the following per day, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan. • **$15** for members of the Standard Option Senior Advantage plan.
• Physical therapy to prevent falls for adults who are at risk for falls when ordered by your doctor.	**$0**
Outpatient substance abuse services We cover the following services for treatment of substance abuse: • Day-treatment programs. • Intensive outpatient programs. • Group substance abuse counseling.	You pay the following per visit (or per day for programs), depending upon the plan in which you are enrolled: • **$2** for members of the High Option Senior Advantage 1 plan.

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Services that are covered for you	What you must pay when you get these services
	• **$5** for members of the High Option Senior Advantage 2 or Standard Option Senior Advantage plans.
• Individual substance abuse counseling. • Medical treatment for withdrawal symptoms.	You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan. • **$15** for members of the Standard Option Senior Advantage plan.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **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.	**Provider office visits** You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan. • **$15** for members of the Standard Option Senior Advantage plan. **Outpatient surgery and other procedures** You pay the following per procedure, depending upon the plan in which you are enrolled, 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

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

Services that are covered for you	What you must pay when you get these services
	monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort: • **$5** for members of the High Option Senior Advantage 1 plan. • **$15** for members of the Standard Option Senior Advantage plan. • **$50** for members of the High Option Senior Advantage 2 plan.
Over-the-Counter (OTC) items for nicotine replacement We cover certain FDA-approved nicotine replacement therapies for over-the-counter use. The items must be ordered by a network provider and obtained from a network pharmacy.	**$0**
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.	**$0**
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.	**Provider office visits** You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan.

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

Services that are covered for you	What you must pay when you get these services
• Second opinion by another network provider prior to surgery. • House calls by a network physician (or a network provider who is a registered nurse) inside our service area when care can best be provided in your home as determined by a network provider. • Pre- and post-operative visits.	• **$15** for members of the Standard Option Senior Advantage plan. **Outpatient surgery** Depending upon the plan in which you are enrolled, 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: • **$5** for members of the High Option Senior Advantage 1 plan. • **$15** for members of the Standard Option Senior Advantage plan. • **$50** for members of the High Option Senior Advantage 2 plan.
• Allergy injection visits. • Certain telehealth services, including: primary and specialty care, which includes cardiac and pulmonary rehabilitation, mental health care, physical, speech, and occupational therapies, substance abuse treatment, kidney disease education, dialysis services, diabetes self-management, 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	**$0**

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

Services that are covered for you	What you must pay when you get these services
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. • 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. • Virtual check-ins (for example, by phone or video chat) with your doctor for 5 to 10 minutes if all of the following are true: ♦ You're not a new patient. ♦ The check-in isn't related to an office visit within the past 7 days. ♦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment. • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours (except weekends and holidays) if all of the following are true: ♦ You're not a new patient. ♦ The check-in isn't related to an office visit within the past 7 days. ♦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment.	
• Consultation your doctor has with other doctors by phone, internet, or electronic health record if you're not a new patient. • Ultraviolet light treatments.	**$0**

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

Services that are covered for you	What you must pay when you get these services
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	**Office visits** You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan. • **$15** for members of the Standard Option Senior Advantage plan. **Outpatient surgery** 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, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$15** for members of the Standard Option Senior Advantage plan. • **$50** for members of the High Option Senior Advantage 2 plan.
Prostate cancer screening exams For men age 50 and older, covered services include the following once every 12 months: • Digital rectal exam.	There is no coinsurance, copayment, or deductible for an annual digital rectal exam or PSA test.

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

Services that are covered for you	What you must pay when you get these services
• Prostate Specific Antigen (PSA) test.	
Prosthetic and orthotic devices and related supplies† • Prosthetic 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). • Covered special footwear when custom made for foot disfigurement due to disease, injury, or developmental disability.	**$0**
Orthotic devices required to support or correct a defective body part, including repair and/or replacement of orthotic devices.	**$0**
We also cover these items not covered by Medicare: • Gradient compression stockings for lymphedema. • Certain surgical boots following surgery when provided during an outpatient visit. • Vacuum erection device for sexual dysfunction. • Certain skin sealants, protectants, moisturizers, ointments that are medically necessary wound care.	**$0**
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.	You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan.

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Services that are covered for you	What you must pay when you get these services
	• **$15** for members of the Standard Option Senior Advantage plan.
Residential substance use disorder and mental health treatment† We cover the following services when the services are provided in a licensed residential treatment facility that provides 24-hour individualized substance use disorder or mental health treatment, the services are generally and customarily provided by a substance use disorder or mental health residential treatment program in 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.	You pay the following, per admission, depending upon the plan in which you are enrolled: • **No charge** for members of the High Option Senior Advantage 1 plan. • **$100** for members of the High Option Senior Advantage 2 or Standard Option Senior Advantage plans.
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	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

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

Services that are covered for you	What you must pay when you get these services
by a qualified primary care doctor or practitioner in a primary care setting.	
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 55–77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.
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	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

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

Services that are covered for you	What you must pay when you get these services
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.	
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. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3). • 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). • Routine laboratory tests to monitor the effectiveness of dialysis. • One routine office visit per month with the nephrology team. • Vascular and peritoneal access procedures when performed in an outpatient hospital setting if certain criteria are met.	**$0**
• Nonroutine office visits with the nephrology team. • Vascular and peritoneal access procedures when performed in a medical office.	You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan.

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

Services that are covered for you	What you must pay when you get these services
	• **$15** for members of the Standard Option Senior Advantage plan.
• 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 booklet. 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. • Laboratory tests ordinarily provided by SNFs. • X-rays and other radiology services ordinarily provided by SNFs.	**$0** A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or skilled nursing facility (SNF). The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 calendar days in a row.

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

Services that are covered for you	What you must pay when you get these services
• 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. The SET program must:	You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan.

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

Services that are covered for you	What you must pay when you get these services
• 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.	• **$15** for members of the Standard Option Senior Advantage plan.
Transportation services* We cover transportation to take you to and from a network provider when provided by our designated transportation provider. Each stop will count towards one trip. To request non-medical transportation services (rideshare, taxi, or private transportation), please call **1-877-930-1477** (TTY **711**), Monday through Friday, 5:00 a.m. to 6:00 p.m. If you need to use non-emergency medical transportation (wheelchair van or gurney van) because you physically or medically are not able to get your medical appointment by non-medical transportation (rideshare, taxi, or private transportation), please call **1-833-226-6760** (TTY **711**), Monday through Friday, 9:00 a.m. to 5:00 p.m. Call at least three business days before your appointment or as soon as you can when you have an urgent appointment. Please have all of the following when you call: • Your Kaiser Permanente ID card. • The date and time of your medical appointments.	• **$0** for 24 one-way trips (50 miles per trip) per calendar year for members of the High Option Senior Advantage 1 plan. • **Not covered** for members of the High Option Senior Advantage 2 or Standard Option Senior Advantage plans.

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

Services that are covered for you	What you must pay when you get these services
• The address of where you need to be picked up and the address of where you are going. • If you will need a return trip. • If someone will be traveling with you (for example, a parent/legal guardian or caregiver).	
Travel benefit†* Kaiser Permanente's travel benefits for Federal employees provide you with outpatient follow-up and/or continuing medical and mental health and substance abuse care when you are temporarily (for example, on a temporary work assignment or attending school) outside your home service area by more than 100 miles and outside of any other Kaiser Permanente service area. These benefits are in addition to your emergency services/accident benefits and include: • Outpatient follow-up care necessary to complete a course of treatment after a covered emergency. Services include removal of stitches, a catheter, or a cast. • Outpatient continuing care for covered services for conditions diagnosed and treated within the previous 12 months by a Kaiser Permanente health care provider or affiliated plan provider. Services include dialysis and prescription drug monitoring. For more information about this benefit, call our Member Service Contact Center. File claims as shown in Chapter 7.	• **$25** for each follow-up and/or continuing care office visit. This amount will be deducted from the reimbursement we make to you or to the provider. We limit our payment for this travel benefit to no more than **$1,200** each calendar year.
Urgently needed services Urgently needed services are provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. • **Inside our service area:** You must obtain urgent care from network providers, unless our provider network is temporarily unavailable or inaccessible	**Office visits** You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan.

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

Services that are covered for you	What you must pay when you get these services
due to an unusual and extraordinary circumstance (for example, major disaster). **Outside our service area:** You have worldwide urgent care coverage when you travel if you need medical attention right away for an unforeseen illness or injury and you reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our service area. Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. **See Chapter 3, Section 3, for more information.**	• **$10** for members of the High Option Senior Advantage 2 plan. • **$15** for members of the Standard Option Senior Advantage plan. **Emergency Department visits** You pay **$75** per visit.
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.	You pay the following per visit, depending upon the plan in which you are enrolled: • **$5** for members of the High Option Senior Advantage 1 plan. • **$10** for members of the High Option Senior Advantage 2 plan. • **$15** for members of the Standard Option Senior Advantage plan.
• Visual field tests.	You pay the following per encounter, depending upon the plan in which you are enrolled: • **$0** for members of the High Option Senior Advantage 1 or High Option Senior Advantage 2 plans. • **$10** for members of the Standard Option Senior Advantage plan.

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

Services that are covered for you	What you must pay when you get these services
• 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. • 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 contact lenses (including fitting and dispensing) after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot 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.
• **Eyeglasses and contact lenses**: Once every 24 months, we provide an allowance for you to use toward the purchase price of eyewear from a plan optical facility when a physician or optometrist prescribes an eyeglass or contact lens for vision correction. The allowance can be used to pay for the following items: ♦ Eyeglass lenses when a network provider puts the lenses into a frame. ♦ Eyeglass frames when a network provider puts two lenses (at least one of which must have refractive value) into the frame. ♦ Contact lenses, fitting, and dispensing. The **allowance** is as follows: ♦ **$200** for members of the High Option Senior Advantage 1 plan.	If the eyewear you purchase costs more than the allowance amount applicable to your plan, **you pay the amount that exceeds your allowance**.

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

Services that are covered for you	What you must pay when you get these services
♦ **$150** for members of the Standard Option Senior Advantage plan. ♦ There is no allowance for members of the High Option Senior Advantage 2 plan. • We will not provide the allowance if we have provided an allowance toward (or otherwise covered) lenses or frames within the previous 24 months. This Senior Advantage allowance cannot be combined with your FEHB coverage. • The allowance can only be used at the initial point of sale. If you do not use all of your allowance at the initial point of sale, you cannot use it later.	
• **Replacement lenses**: If you have a change in prescription of at least .50 diopter in one or both eyes within 12 months of the initial point of sale of an eyeglass lens or contact lens that we provided an allowance toward (or otherwise covered) we will provide an allowance toward the purchase price of a replacement item of the same type (eyeglass lens, or contact lens, fitting, and dispensing) for the eye that had the .50 diopter change. The allowance toward one of these replacement lenses is **$30** for a single vision eyeglass lens or for a contact lens (including fitting and dispensing) and **$45** for a multifocal or lenticular eyeglass lens.	If the lens you purchase costs more than the **$30** allowance for single vision or **$45** for multifocal or lenticular eyeglass lens, you pay the amount that exceeds your allowance.
• **Special contact lenses**: We cover the following special contact lenses when prescribed by a network physician or network provider who is an optometrist: ♦ Up to two medically necessary contact lenses, fitting, and dispensing per eye every 12 months to treat aniridia (missing iris). ♦ If contact lenses (other than contact lenses for aniridia) will provide a significant improvement in your vision that eyeglass lenses cannot provide, we cover either one pair of contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses (including fitting and dispensing) not more than once every 24 months. However, we will not cover any contact lenses if	**$0**

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

Services that are covered for you	What you must pay when you get these services
we provided an allowance toward (or otherwise covered) a contact lens within the previous 24 months, but not including covered contact lenses for aniridia.	
For members of the High Option Senior Advantage 1 and High Option Senior Advantage 2 plans, please refer to your FEHB Brochure (RI 73-889) for a description of your additional non-FEHB vision coverage.	
"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 10) and Chapter 11 for information about coordination of benefits that applies to all covered services described in this Medical Benefits Chart.	

Section 2.2 – Additional chiropractic services*

Kaiser Foundation Health Plan, Inc. contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to make the network of ASH participating providers available to you. When you need chiropractic care, you have direct access to more than 3,400 licensed chiropractors in California. You can obtain covered services from any ASH participating provider without a referral from a plan physician. Your cost share is due when you receive covered services.

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

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

services that are not available from contracted providers and that are authorized in advance by ASH Plans.

How to obtain services

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

Decision time frames

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

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

Covered services

We cover the services listed in this "Covered services" section, subject to exclusions described in Section 3 of this Chapter, only if all of the following conditions are satisfied:

- You are a member on the date that you receive the services.
- ASH Plans has determined that the services are medically necessary, except for:
  - The initial examination described under "Office visits" in this "Covered services" section.
  - Services covered under "Emergency and urgent services" in this "Covered services" section.

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

- You receive the services from ASH participating providers or other licensed providers with which ASH contracts to provide covered care, except for:
  - Services covered under "Emergency and urgent services" in this "Covered chiropractic services" section.
  - Services that are not available from ASH participating providers or other licensed providers with which ASH contracts to provide covered care and that are authorized in advance by ASH Plans.

When you receive covered services, you must pay the cost share listed in this "Covered services" section. If you receive services that are not covered under this "Additional chiropractic services" section, you may be liable for the full price of those services.

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

If you have questions about your cost share for specific services that you are scheduled to receive or that your provider orders during a visit or procedure, please call ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**) weekdays from 5 a.m. to 6 p.m.

Services that are covered for you	What you must pay when you get these services
Office visits We cover up to a combined total of 20 of the following types of office visits per calendar year. Each office visit counts toward the visit limit: • **Initial chiropractic examination:** An examination performed by an ASH participating provider to determine the nature of your problem (and, if appropriate, to prepare a treatment plan), and to provide medically necessary chiropractic services, which may include an adjustment and adjunctive therapy. We cover an initial examination only if you have not already received covered chiropractic services from an ASH participating provider in the same 12-month period for your musculoskeletal and related disorder. • **Subsequent chiropractic office visits:** Subsequent ASH participating provider office visits for chiropractic services that are determined to be medically necessary by an ASH Plans clinician. These subsequent office visits may include an adjustment, adjunctive therapy, and a re-examination	**$15** per visit.

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

Services that are covered for you	What you must pay when you get these services
to assess the need to continue, extend, or change a treatment plan.	
Laboratory tests and x-rays We cover medically necessary laboratory tests and X-rays when prescribed as part of covered chiropractic care described under "Office visits" in this "Covered services" section when an ASH participating provider provides the services or refers you to another licensed provider with which ASH contracts to provide covered services.	**No charge**
Chiropractic supports and appliances We provide a $50 allowance per 12-month period toward the ASH Plans fee schedule price for chiropractic appliances listed in this paragraph when the item is prescribed and provided to you by an ASH participating provider as part of covered chiropractic care described under "Office visits" in this "Covered services" section. If the price of the item(s) in the ASH Plans fee schedule exceeds $50 (the allowance), you will pay the amount in excess of $50. Covered chiropractic appliances are limited to: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle braces, knee braces, rib supports, and wrist braces.	If the appliance you purchase costs more than $50, **you pay the difference.**
Second opinions You may request a second opinion in regard to covered services by contacting another ASH participating provider. Your visit to another ASH participating provider for a second opinion generally will count toward any calendar year visit limit. An ASH participating provider may also request a second opinion in regard to covered services by referring you to another ASH participating provider in the same or similar specialty. When you are referred by a participating provider to another ASH participating	**$15** per visit.

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

Services that are covered for you	What you must pay when you get these services
provider for a second opinion, your visit to the other ASH participating provider will not count toward any calendar year visit limit. An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial, and of your right to file a grievance as described under "Grievances" in this "Additional chiropractic services" section.	
Emergency and urgent services covered under this "Additional chiropractic services" section We cover emergency chiropractic services and urgent chiropractic services provided by an ASH participating provider or a non–participating provider. We do not cover follow-up or continuing care from a non-participating provider unless ASH Plans has authorized the services in advance. Also, we do not cover services from a non-participating provider that ASH Plans determines are not emergency chiropractic services or urgent chiropractic services. **How to file a claim.** As soon as possible after receiving emergency chiropractic services or urgent chiropractic services, you must file an ASH Plans claim form. To request a claim form or for more information, please call ASH Plans toll free at **1-800-678-9133** (TTY users call **711**) or visit the ASH Plans website at **ashlink.com**. You must send the completed claim form to: ASH Plans P.O. Box 509002 San Diego, CA 92150-9002	**$15** per visit.

ASH Plans Customer Service

If you have a question or concern regarding the services you received from an ASH participating provider or any other licensed provider with which ASH contracts to provide covered services, you may call the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**) weekdays from 5 a.m. to 6 p.m., or write ASH Plans at:

ASH Plans

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

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

Grievances

You can file a grievance with Kaiser Permanente regarding any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about services you received. You may submit your grievance orally or in writing to Kaiser Permanente as described in Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)."

Section 2.3 – Fitness benefit* (The Silver&Fit® Exercise and Healthy Aging Program)

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.

Services that are covered for you	What you must pay when you get these services
Fitness benefit (Silver&Fit® Healthy Aging and Exercise Program) The Silver&Fit program includes the following: • 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	• **No charge** for members of the High Option Senior Advantage 2 plan. • **Not covered** for members of the High Option Senior Advantage 1 or Standard Option Senior Advantage plans.

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

Services that are covered for you	What you must pay when you get these services
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 digital workout videos, the Get Started program, Healthy Aging educational materials, newsletters, online classes, and other helpful features. 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.	
For more information about the Silver&Fit program and the list of participating fitness centers and fitness kits, visit **kp.org/silverandfit** or call Silver&Fit customer service at **1-877-750-2746** (TTY users should call **711**), Monday through Friday, 5 a.m. to 6 p.m. (PST).	

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

Section 2.4 – DeltaCare USA Dental HMO Program for members enrolled in the High Option Senior Advantage 1 or Standard Option Senior Advantage plans

Kaiser Foundation Health Plan, Inc. has an agreement with Delta Dental of California ("Delta Dental") to offer you DeltaCare USA Dental HMO Program. DeltaCare USA provides comprehensive dental care through a network of dentists that contract with Delta Dental to provide dental services. For information about dental providers, please refer to the DeltaCare USA provider directory.

The benefits shown below are performed as deemed appropriate by the attending DeltaCare USA dentist subject to the limitations and exclusions stated in Section 3 of this chapter. Members should discuss all treatment options with their DeltaCare USA dentist prior to services being rendered. If services for a listed procedure are performed by the assigned DeltaCare USA dentist, the member pays the specified cost-sharing. For services to be covered, members must receive the dental care from their assigned DeltaCare USA dentist, except for emergencies and written authorizations for specialty care from Delta Dental. If a procedure isn't listed below, it isn't covered.

Text that appears in italics in the chart below is specifically intended to clarify the delivery of benefits under the DeltaCare USA Dental HMO programs and is not to be interpreted as Current Dental Terminology (CDT) procedure codes, nomenclature or descriptors that are under copyright by the American Dental Association (ADA). The ADA may periodically update CDT procedure codes, nomenclature or descriptors. Such updates may be used to describe these covered procedures in compliance with federal legislation.

DeltaCare USA Dental HMO Program*†	What you must pay*
Accident Injury Benefit*† An accidental injury is damage to the hard and soft tissue of the mouth caused directly and independently of all other causes by external forces. Damage to the hard and soft tissue of the mouth from normal chewing function is covered under the DeltaCare USA Dental HMO Program. Delta Dental will pay up to 100% of the DeltaCare USA dentist's "filed fees," for expenses an Enrollee incurs for an accident injury, less any applicable Copayment(s), up to a maximum of **$1,600 in any 12-month period**. Accident injury benefits include the following procedure in addition to those listed in the chart below; D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus - includes splinting and/or stabilization. Payment of accident injury benefits is subject to any applicable limitations and exclusions of benefits.	You pay any amounts that exceed the **$1,600 maximum in any 12-month period**.

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Note: You must pay a $5 copayment (D0999) each time you receive dental care in addition to any other cost-sharing listed above.

DeltaCare USA Dental HMO Program*†	What you must pay*
Emergency Dental Care*† If you need emergency dental care, you should contact your assigned DeltaCare USA dentist or Delta Dental Customer Service at **1-800-422-4234**, Monday through Friday, 8 a.m. to 8 p.m. (TTY users should call **1-800-735-2929**).	
• Covered emergency dental care received from your assigned DeltaCare USA dentist.	**Same cost-sharing as nonemergency dental care.**
• Covered emergency dental care received from a dentist other than your assigned DeltaCare USA dentist is limited to **$100 per emergency**, less your cost-sharing. Also, covered emergency care is limited to necessary care required to stabilize your condition and provide palliative relief. In addition, if the following conditions are not met, you are responsible for the full cost of the dental care: ♦ You made a reasonable attempt to contact your assigned DeltaCare USA dentist and you cannot be seen within 24 hours or you believe that your condition makes it unreasonable or impossible to travel to your assigned DeltaCare USA dentist. If you are a new member without an assigned dentist yet, you should contact Delta Dental Customer Service for help in locating a DeltaCare USA dentist. ♦ You called Delta Dental Customer Service prior to receiving emergency dental care, or it is reasonable for you to get emergency dental care without calling Customer Service considering your condition and the circumstances. ♦ Claims for covered emergency dental services must be submitted to Delta Dental within 90 days of the treatment date unless you can prove that it was not reasonably possible to submit the claim within that time. In which case, the claim must be received within one year of the treatment date. Send your claim to: Delta Dental Claims Department, P.O. Box 1810, Alpharetta, GA 30023.	You pay any amounts that exceed the **$100 maximum,** less your applicable cost-sharing.
DeltaCare USA HMO Program Customer Service If you have a question or concern regarding the services you received from a participating DeltaCare USA dentist or any other licensed provider with which Delta Dental contracts to	

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DeltaCare USA Dental HMO Program*†	**What you must pay***
provide covered services, you may call the Delta Dental Customer Service Department toll free at **1-800-422-4234** (TTY users call **1-800-735-2929**) weekdays from 8 a.m. to 8 p.m.	
Diagnostic (D0100-D0999) • D0999: Unspecified diagnostic procedure, by report –includes office visit, per visit (in addition to other services). • **Note:** The **$5** copayment applies to every visit and is in addition to the other cost-sharing listed in this chart applicable to the services you receive.	**$5** per visit
• D0120: Periodic oral evaluation – established patient.	**$0**
• D0140: Limited oral evaluation – problem focused.	**$0**
• D0145: Oral evaluation for a patient under three years of age and counseling with primary caregiver.	**$0**
• D0150: Comprehensive oral evaluation – new or established patient.	**$0**
• D0160: Detailed and extensive oral evaluation – problem focused, by report.	**$0**
• D0170: Re-evaluation – limited, problem focused (established patient; not post-operative visit).	**$0**
• D0171: Re-evaluation – post-operative office visit (during regularly scheduled hours).	**$5**
• D0180: Comprehensive periodontal evaluation – new or established patient.	**$0**
• D0190: Screening of a patient.	**$0**
• D0191: Assessment of a patient.	**$0**
• D0210: Intraoral – complete series of radiographic images – limited to 1 series every 36 months.	**$0**

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DeltaCare USA Dental HMO Program*†	What you must pay*
• D0220: Intraoral – periapical first radiographic image.	**$0**
• D0230: Intraoral – periapical each additional radiographic image.	**$0**
• D0240: Intraoral – occlusal radiographic image.	**$0**
• D0270: Bitewing – single radiographic image.	**$0**
• D0272: Bitewings – two radiographic images.	**$0**
• D0273: Bitewings – three radiographic images.	**$0**
• D0274: Bitewings – four radiographic images – limited to 1 series every 6 months.	**$0**
• D0330: Panoramic radiographic image – limited to 1 each 36-month period.	**$0**
• D0419: Assessment of salivary flow by measurement – 1 every 12 months.	**$0**
• D0460: Pulp vitality tests.	**$0**
• D0470: Diagnostic casts.	**$0**
• D0472: Accession of tissue, gross examination, preparation and transmission of written report.	**$0**
• D0473: Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	**$0**
• D0474: Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	**$0**

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DeltaCare USA Dental HMO Program*†	What you must pay*
• D0601: Caries risk assessment and documentation, with a finding of low risk –1 every 12 months.	**$0**
• D0602: Caries risk assessment and documentation, with a finding of moderate risk –1 every 12 months.	**$0**
• D0603: Caries risk assessment and documentation, with a finding of high risk –1 every 12 months.	**$0**
Preventive (D1000-D1999)	
• D1110: Prophylaxis cleaning – adult – 1 per 6-month period.	**$15**
• D1310: Nutritional counseling for control of dental disease.	**$0**
• D1330: Oral hygiene instructions.	**$0**
Restorative (D2000-D2999) Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.	
• D2140: Amalgam – one surface, primary or permanent.	**$27**
• D2150: Amalgam – two surfaces, primary or permanent.	**$32**
• D2160: Amalgam – three surfaces, primary or permanent.	**$37**
• D2161: Amalgam – four or more surfaces, primary or permanent.	**$50**
• D2330: Resin-based composite – one surface, anterior.	**$55**
• D2331: Resin-based composite – two surfaces, anterior.	**$65**
• D2332: Resin-based composite – three surfaces, anterior.	**$75**

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DeltaCare USA Dental HMO Program*†	What you must pay*
• D2335: Resin-based composite – four or more surfaces or involving incisal angle (anterior).	**$85**
• D2391: Resin-based composite – one surface, posterior.	**$75**
• D2392: Resin-based composite – two surfaces, posterior.	**$80**
• D2393: Resin-based composite – three surfaces, posterior.	**$85**
• D2394: Resin-based composite – four or more surfaces, posterior.	**$85**
• D2510: Inlay – metallic – one surface.[1, 4]	**$260**
• D2520: Inlay – metallic – two surfaces.[1, 4]	**$270**
• D2530: Inlay – metallic – three or more surfaces.[1, 4]	**$280**
• D2542: Onlay – metallic – two surfaces.[1, 4]	**$278**
• D2543: Onlay – metallic – three surfaces.[1, 4]	**$290**
• D2544: Onlay – metallic – four or more surfaces.[1, 4]	**$300**
• D2610: Inlay – porcelain/ceramic – one surface.[1, 3]	**Optional**
• D2620: Inlay – porcelain/ceramic – two surfaces.[1, 3]	**Optional**
• D2630: Inlay – porcelain/ceramic – three or more surfaces.[1, 3]	**Optional**
• D2642: Onlay – porcelain/ceramic – two surfaces.[1, 3]	**Optional**
• D2643: Onlay – porcelain/ceramic – three surfaces.[1, 3]	**Optional**
• D2644: Onlay – porcelain/ceramic – four or more surfaces.[1, 3]	**Optional**

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DeltaCare USA Dental HMO Program*†	What you must pay*
• D2650: Inlay – resin-based composite – one surface.[1, 3]	**Optional**
• D2651: Inlay – resin-based composite – two surfaces.[1, 3]	**Optional**
• D2652: Inlay – resin-based composite – three or more surfaces.[1, 3]	**Optional**
• D2662: Onlay – resin-based composite – two surfaces.[1, 3]	**Optional**
• D2663: Onlay – resin-based composite – three surfaces.[1, 3]	**Optional**
• D2664: Onlay – resin-based composite – four or more surfaces. [1, 3]	**Optional**
• D2710: Crown – resin-based composite (indirect).[1, 8]	**$125**
• D2712: Crown – ¾ resin-based composite (indirect).[1, 8]	**$125**
• D2720: Crown – resin with high noble metal.[1, 8]	**$395**
• D2721: Crown – resin with predominantly base metal.[1, 8]	**$315**
• D2722: Crown – resin with noble metal.[1, 8]	**$350**
• D2740: Crown – porcelain/ceramic.[1, 8]	**$300**
• D2750: Crown – porcelain fused to high noble metal.[1, 8]	**$395**
• D2751: Crown – porcelain fused to predominantly base metal.[1, 8]	**$315**
• D2752: Crown – porcelain fused to noble metal.[1, 8]	**$350**
• D2753: Crown – porcelain fused to titanium or titanium alloy.	**$395**
• D2780: Crown – ¾ cast high noble metal.[1]	**$335**

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Note: You must pay a $5 copayment (D0999) each time you receive dental care in addition to any other cost-sharing listed above.

DeltaCare USA Dental HMO Program*†	What you must pay*
• D2781: Crown – ¾ cast predominantly base metal. [1]	**$300**
• D2782: Crown – ¾ cast noble metal.[1]	**$335**
• D2790: Crown – full cast high noble metal.[1]	**$365**
• D2791: Crown – full cast predominantly base metal.[1]	**$300**
• D2792: Crown – full cast noble metal.[1]	**$335**
• D2794: Crown – titanium and titanium alloy.[1]	**$365**
• D2910: Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.	**$20**
• D2915: Re-cement or re-bond indirectly fabricated or prefabricated post and core.	**$20**
• D2920: Re-cement or re-bond crown.	**$20**
• D2921: Reattachment of tooth fragment, incisal edge or cusp (anterior).	**$85**
• D2932: Prefabricated resin crown.	**$60**
• D2940: Protective restoration.	**$0**
• D2941: Interim therapeutic restoration – primary dentition.	**$0**
• D2949: Restorative foundation for an indirect restoration.	**$50**
• D2950: Core buildup, including any pins when required.	**$50**
• D2951: Pin retention – per tooth, in addition to restoration.	**$25**

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DeltaCare USA Dental HMO Program*†	What you must pay*
• D2952: Post and core in addition to crown, indirectly fabricated – includes canal preparation.[4]	**$95**
• D2953: Each additional indirectly fabricated post – same tooth – includes canal preparation.[4]	**$95**
• D2954: Prefabricated post and core in addition to crown – base metal post; includes canal preparation.	**$70**
• D2957: Each additional prefabricated post – same tooth – base metal post; includes canal preparation.	**$70**
• D2980: Crown repair necessitated by restorative material failure.	**$45**
• D2981: Inlay repair necessitated by restorative material failure.	**$45**
• D2982: Onlay repair necessitated by restorative material failure.	**$45**
• D2983: Veneer repair necessitated by restorative material failure.	**$45**
Endodontics (D3000-D3999) When referable services are provided by a Participating Specialty Care Dentist, the Enrollee pays 75% of that Dentist's usual fee.	
• D3220: Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament.	**$0**
• D3221: Pulpal debridement, primary and permanent teeth.	**$35**
• D3222: Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development.	**$0**
• D3310: Root canal – endodontic therapy, anterior tooth (excluding final restoration).[6]	**$180**

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DeltaCare USA Dental HMO Program*†	What you must pay*
• D3320: Root canal – endodontic therapy, premolar tooth (excluding final restoration).[6]	**$230**
• D3330: Root canal – endodontic therapy, molar tooth (excluding final restoration).[6]	**$375**
• D3346: Retreatment of previous root canal therapy – anterior.[6]	**$280**
• D3347: Retreatment of previous root canal therapy – premolar.[6]	**$330**
• D3348: Retreatment of previous root canal therapy – molar.[6]	**$475**
• D3410: Apicoectomy – anterior.[6]	**$270**
• D3421: Apicoectomy – premolar (first root).[6]	**$335**
• D3425: Apicoectomy – molar (first root).[6]	**$380**
• D3426: Apicoectomy (each additional root).[6]	**$105**
• D3430: Retrograde filling – per root.[6]	**$25**
• D3450: Root amputation, per root – not covered in conjunction with a hemisection.[6]	**$75**
• D3471: Surgical repair of root resorption – anterior.	**$270**
• D3472: Surgical repair of root resorption – posterior.	**$270**
• D3473: Surgical repair of root resorption – molar.	**$270**
• D3501: Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior.	**$270**

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DeltaCare USA Dental HMO Program*†	What you must pay*
• D3502: Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar.	**$270**
• D3503: Surgical exposure of root surface without apicoectomy or repair of root resorption – molar.	**$270**
Periodontics (D4000-D4999) Includes preoperative and postoperative evaluations and treatment under local anesthetic.	
• D4210: Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant.	**$300**
• D4211: Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant.	**$50**
• D4212: Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth.	**$50**
• D4240: Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant.	**$300**
• D4241: Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant.	**$300**
• D4260: Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant.	**$450**
• D4261: Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant.	**$450**
• D4341: Periodontal scaling and root planing – four or more teeth per quadrant – limited to 4 quadrants during any 12 consecutive months.	**$55**
• D4342: Periodontal scaling and root planing – one to three teeth per quadrant – limited to 4 quadrants during any 12 consecutive months.	**$55**

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DeltaCare USA Dental HMO Program*†	What you must pay*
• D4346: Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation – 1 D1110 or D4346 per 6-month period.	**$15**
• D4355: Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit – limited to 1 treatment in any 12 consecutive months.	**$55**
• D4910: Periodontal maintenance – limited to 1 treatment each 6-month period.	**$45**
• D4921: Gingival irrigation – per quadrant.	**$0**
Prosthodontics, removable (D5000-D5899)	
• D5110: Complete denture – maxillary.[2, 7]	**$395**
• D5120: Complete denture – mandibular.[2, 7]	**$395**
• D5130: Immediate denture – maxillary.[2, 7]	**$495**
• D5140: Immediate denture – mandibular.[2, 7]	**$495**
• D5211: Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth).[2, 7]	**$300**
• D5212: Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth).[2, 7]	**$300**
• D5213: Maxillary partial denture – cast metal framework with resin denture bases (including any retentive/clasping materials, rests, and teeth).[2, 7]	**$395**
• D5214: Mandibular partial denture – cast metal framework with resin denture bases (including any retentive/clasping materials, rests, and teeth).[2, 7]	**$395**

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DeltaCare USA Dental HMO Program*†	What you must pay*
• D5221: Immediate maxillary partial denture – resin base (including any retentive/clasping materials, rests, and teeth).	**$300**
• D5222: Immediate mandibular partial denture – resin base (including any retentive/clasping materials, rests, and teeth).	**$300**
• D5223: Immediate maxillary partial denture – cast metal framework with resin denture bases (including any retentive/clasping materials, rests, and teeth).	**$395**
• D5224: Immediate mandibular partial denture – cast metal framework with resin denture bases (including any retentive/clasping materials, rests, and teeth).	**$395**
• D5410: Adjust complete denture – maxillary.[2]	**$20**
• D5411: Adjust complete denture – mandibular.[2]	**$20**
• D5421: Adjust partial denture – maxillary.[2]	**$20**
• D5422: Adjust partial denture – mandibular.[2]	**$20**
• D5511: Repair broken complete denture base, mandibular.	**$50**
• D5512: Repair broken complete denture base, maxillary.	**$50**
• D5520: Replace missing or broken teeth – complete denture (each tooth).	**$25**
• D5611: Repair resin partial denture base, mandibular.	**$50**
• D5612: Repair resin partial denture base, maxillary.	**$50**
• D5621: Repair cast partial framework, mandibular.	**$90**

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DeltaCare USA Dental HMO Program*†	What you must pay*
• D5622: Repair cast partial framework, maxillary.	**$90**
• D5630: Repair or replace broken retentive/clasping materials – per tooth.	**$45**
• D5640: Replace broken teeth – per tooth.	**$25**
• D5650: Add tooth to existing partial denture.	**$45**
• D5660: Add clasp to existing partial denture – per tooth.	**$45**
• D5710: Rebase complete maxillary denture.[9]	**$130**
• D5711: Rebase complete mandibular denture.[9]	**$130**
• D5720: Rebase maxillary partial denture.[9]	**$130**
• D5721: Rebase mandibular partial denture.[9]	**$130**
• D5725: Rebase hybrid prosthesis.	**$130**
• D5730: Reline complete maxillary denture (chairside).[9]	**$50**
• D5731: Reline complete mandibular denture (chairside).[9]	**$50**
• D5740: Reline maxillary partial denture (chairside).[9]	**$50**
• D5741: Reline mandibular partial denture (chairside).[9]	**$50**
• D5750: Reline complete maxillary denture (laboratory).[9]	**$150**
• D5751: Reline complete mandibular denture (laboratory).[9]	**$150**
• D5760: Reline maxillary partial denture (laboratory).[9]	**$150**

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DeltaCare USA Dental HMO Program*†	What you must pay*
• D5761: Reline mandibular partial denture (laboratory).[9]	**$150**
• D5765: Soft liner for complete or partial removable denture – indirect.	**$150**
• D5820: Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary – limited to initial placement of interim partial denture/stayplate to replace extracted anterior teeth during healing.[2]	**$55**
• D5821: Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular – limited to initial placement of interim partial denture/stayplate to replace extracted anterior teeth during healing.[2]	**$55**
• D5850: Tissue conditioning, maxillary.[2, 9]	**$30**
• D5851: Tissue conditioning, mandibular.[2, 9]	**$30**
• D5863: Overdenture – complete maxillary.	**Optional**
• D5864: Overdenture – partial maxillary.	**Optional**
• D5865: Overdenture – complete mandibular.	**Optional**
• D5866: Overdenture – partial mandibular.	**Optional**
Maxillofacial Prosthetics (D5900-D5999)	**Not covered**
Implant Services (D6000-D6199)	**Not covered**
Prosthodontics, fixed (D6200-D6999) Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge).	

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DeltaCare USA Dental HMO Program*†	What you must pay*
• D6210: Pontic – cast high noble metal.[5]	**$365**
• D6211: Pontic – cast predominantly base metal.[5]	**$300**
• D6212: Pontic – cast noble metal.[5]	**$300**
• D6240: Pontic – porcelain fused to high noble metal.[5, 8]	**$395**
• D6241: Pontic – porcelain fused to predominantly base metal.[5, 8]	**$315**
• D6242: Pontic – porcelain fused to noble metal.[5, 8]	**$350**
• D6243: Pontic – porcelain fused to titanium or titanium alloys.	**$350**
• D6245: Pontic – porcelain/ceramic.[3, 5]	**Optional**
• D6250: Pontic – resin with high noble metal.[5, 8]	**$395**
• D6251: Pontic – resin with predominantly base metal.[5, 8]	**$315**
• D6252: Pontic – resin with noble metal.[5, 8]	**$350**
• D6600: Retainer inlay – porcelain/ceramic, two surfaces.[3, 5]	**Optional**
• D6601: Retainer inlay – porcelain/ceramic, three or more surfaces.[3, 5]	**Optional**
• D6602: Retainer inlay – cast high noble metal, two surfaces.[4, 5]	**$270**
• D6603: Retainer inlay – cast high noble metal, three or more surfaces.[4, 5]	**$280**
• D6604: Retainer inlay – cast predominantly base metal, two surfaces.[5]	**$270**

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DeltaCare USA Dental HMO Program*†	What you must pay*
• D6605: Retainer inlay – cast predominantly base metal, three or more surfaces.[5]	**$280**
• D6606: Retainer inlay – cast noble metal, two surfaces.[5]	**$270**
• D6607: Retainer inlay – cast noble metal, three or more surfaces.[5]	**$280**
• D6608: Retainer onlay – porcelain/ceramic, two surfaces.[3, 5]	**Optional**
• D6609: Retainer onlay – porcelain/ceramic, three or more surfaces.[3, 5]	**Optional**
• D6610: Retainer onlay – cast high noble metal, two surfaces.[4, 5]	**$290**
• D6611: Retainer onlay – cast high noble metal, three or more surfaces.[4, 5]	**$290**
• D6612: Retainer onlay – cast predominantly base metal, two surfaces.[5]	**$290**
• D6613: Retainer onlay – cast predominantly base metal, three or more surfaces.[5]	**$290**
• D6614: Retainer onlay – cast noble metal, two surfaces.[5]	**$290**
• D6615: Retainer onlay – cast noble metal, three or more surfaces.[5]	**$290**
• D6720: Retainer crown – resin with high noble metal.[5, 8]	**$395**
• D6721: Retainer crown – resin with predominantly base metal.[5, 8]	**$315**
• D6722: Retainer crown – resin with noble metal.[5, 8]	**$350**
• D6740: Retainer crown – porcelain/ceramic.[3, 5]	**Optional**
• D6750: Retainer crown – porcelain fused to high noble metal.[5, 8]	**$395**

†The dentist may need to get prior authorization from Delta Dental.
*Cost-sharing for these services or items doesn't apply to the maximum out-of-pocket amount.
Note: You must pay a $5 copayment (D0999) each time you receive dental care in addition to any other cost-sharing listed above.

DeltaCare USA Dental HMO Program*†	**What you must pay***
• D6751: Retainer crown – porcelain fused to predominantly base metal.[5, 8]	**$315**
• D6752: Retainer crown – porcelain fused to noble metal.[5, 8]	**$350**
• D6753: Retainer crown – porcelain fused to titanium or titanium alloys.	**$395**
• D6780: Retainer crown – ¾ cast high noble metal.[5]	**$335**
• D6781: Retainer crown – ¾ cast predominantly base metal.[5]	**$300**
• D6782: Retainer crown – ¾ cast noble metal.[5]	**$335**
• D6784: Retainer crown – ¾ cast titanium and titanium alloys.	**$365**
• D6790: Retainer crown – full cast high noble metal.[5]	**$365**
• D6791: Retainer crown – full cast predominantly base metal.[5]	**$300**
• D6792: Retainer crown – full cast noble metal.[5]	**$335**
• D6930: Re-cement or re-bond fixed partial denture.	**$30**
• D6940: Stress breaker.[5]	**$50**
• D6980: Fixed partial denture repair necessitated by restorative material failure.	**$45**
Oral & Maxillofacial Surgery (D7000-D7999) Includes preoperative and postoperative evaluations and treatment under local anesthetic.	
• D7111: Extraction, coronal remnants – primary tooth.	**$35**

†The dentist may need to get prior authorization from Delta Dental.
*Cost-sharing for these services or items doesn't apply to the maximum out-of-pocket amount.
Note: You must pay a $5 copayment (D0999) each time you receive dental care in addition to any other cost-sharing listed above.

DeltaCare USA Dental HMO Program*†	What you must pay*
• D7140: Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	**$35**
• D7210: Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	**$65**
• D7220: Removal of impacted tooth – soft tissue.	**$75**
• D7230: Removal of impacted tooth – partially bony.	**$100**
• D7240: Removal of impacted tooth – completely bony.	**$140**
• D7241: Removal of impacted tooth – completely bony, with unusual surgical complications.	**$160**
• D7250: Removal of residual tooth roots (cutting procedure).	**$65**
• D7251: Coronectomy – intentional partial tooth removal.	**$160**
• D7286: Incisional biopsy of oral tissue – soft – does not include pathology laboratory procedures.	**$60**
• D7310: Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant.	**$50**
• D7311: Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant.	**$50**
• D7320: Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant.	**$105**
• D7321: Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant.	**$105**
• D7471: Removal of lateral exostosis (maxilla or mandible).	**$200**

†The dentist may need to get prior authorization from Delta Dental.
*Cost-sharing for these services or items doesn't apply to the maximum out-of-pocket amount.
Note: You must pay a $5 copayment (D0999) each time you receive dental care in addition to any other cost-sharing listed above.

DeltaCare USA Dental HMO Program*†	**What you must pay***
• D7510: Incision and drainage of abscess – intraoral soft tissue.	**$35**
• D7922: Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site.	**$0**
• D7961: Buccal/labial frenectomy (frenulectomy).	**$75**
• D7962: Lingual frenectomy (frenulectomy).	**$75**
Orthodontics (D8000-D8999)	**Not covered**
Adjunctive General Services (D9000-D9999)	
• D9110: Palliative (emergency) treatment of dental pain – minor procedure.	**$35**
• D9211: Regional block anesthesia.	**$0**
• D9212: Trigeminal division block anesthesia.	**$0**
• D9215: Local anesthesia in conjunction with operative or surgical procedures.	**$0**
• D9219: Evaluation for moderate sedation, deep sedation, or general anesthesia.	**$0**
• D9310: Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician.	**$35**
• D9311: Consultation with medical health care professional.	**$0**
• D9430: Office visit for observation (during regularly scheduled hours) – no other services performed.	**$5**
• D9440: Office visit – after regularly scheduled hours.	**$50**

†The dentist may need to get prior authorization from Delta Dental.
*Cost-sharing for these services or items doesn't apply to the maximum out-of-pocket amount.
Note: You must pay a $5 copayment (D0999) each time you receive dental care in addition to any other cost-sharing listed above.

DeltaCare USA Dental HMO Program*†	What you must pay*
• D9912: Pre-visit patient screening.	**$0**
• D9932: Cleaning and inspection of removable complete denture, maxillary.	**$0**
• D9933: Cleaning and inspection of removable complete denture, mandibular.	**$0**
• D9934: Cleaning and inspection of removable partial denture, maxillary.	**$0**
• D9935: Cleaning and inspection of removable partial denture, mandibular.	**$0**
• D9986: Missed appointment – *without 24-hour notice – per 15 minutes of appointment time – up to an overall maximum of $40*.	**$10**
• D9987: Canceled appointment – *without 24-hour notice – per 15 minutes of appointment time – up to an overall maximum of $40*.	**$10**
• D9990: Certified translation or sign-language services – per visit.	**$0**
• D9991: Dental case management – addressing appointment compliance barriers.	**$0**
• D9992: Dental case management – care coordination.	**$0**
• D9995: Teledentistry – synchronous; real-time encounter.	**$0**
• D9996: Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review.	**$0**
• D9997: Dental case management – Patients with special Health Care Needs.	**$0**

†The dentist may need to get prior authorization from Delta Dental.
*Cost-sharing for these services or items doesn't apply to the maximum out-of-pocket amount.
Note: You must pay a $5 copayment (D0999) each time you receive dental care in addition to any other cost-sharing listed above.

Footnotes

[1] Replacement is subject to a limitation requiring the existing restoration to be 5+ years old.

[2] Includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement, if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.

[3] Optional is defined as any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee, and is subject to the Limitations and Exclusions of the program. The applicable charge to the Enrollee is the difference between the Contract Dentist's "filed fee" for the Optional procedure and the "filed fee" for the covered procedure, plus any applicable Copayment for the covered procedure. "Filed fees" means the Contract Dentist's fees on file with Delta Dental. Questions regarding the DeltaCare USA program should be directed to Delta Dental's Customer Service department at **1-800-422-4234**.

[4] Base or noble metal is the benefit. High noble metal (precious), if used, will be charged to the Enrollee at the additional maximum cost to the Enrollee of $100.00 per tooth. If an indirectly fabricated post and core is made of high noble metal, an additional fee up to $100.00 per tooth will be charged for the upgrade. This charge also applies to a titanium crown.

[5] Replacement is subject to a limitation requiring the existing bridge to be 5+ years old.

[6] A Benefit for permanent teeth only.

[7] Replacement is subject to limitation requiring the existing denture to be 5+ years old.

[8] Porcelain and other tooth-colored materials on molars are considered a material upgrade with a maximum additional charge to the Enrollee of $75.00.

[9] Limited to 1 per denture during any 12 consecutive months.

†The dentist may need to get prior authorization from Delta Dental.
*Cost-sharing for these services or items doesn't apply to the maximum out-of-pocket amount.
Note: You must pay a $5 copayment (D0999) each time you receive dental care in addition to any other cost-sharing listed above.

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. If a service is "excluded," it means that we don't cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions. Also, please refer to your FEHB brochure (RI 73-889) as additional exclusions may apply and exclusions listed below may be covered under the FEHB Program as described in the FEHB brochure.

If you get services that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception is we will pay if a service in the chart below is found 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 booklet.)

All exclusions or limitations on services are described in the Medical Benefits Chart or in the chart 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.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Care in an intermediate or residential care facility, assisted living facility, or adult foster home		✓ Covered as described in "Residential substance abuse 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 not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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.
Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing 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, athletic performance, cosmetic purposes, anti-		✓ Covered if medically necessary and covered under Original Medicare.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
aging, and mental performance)		
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.)
The following eyewear services and items: • Lens protection plan. • Nonprescription products. • Lenses and sunglasses without refractive value, except that this exclusion doesn't apply to a clear balance lens if only one eye needs correction or tinted lenses when medically necessary to treat macular degeneration or retinitis pigmentosa. • Replacement of lost, broken, or damaged lenses or frames. • Eyeglass or contact lens adornment. • Eyewear items that do not require a prescription by law	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
(other than eyeglass frames or a covered balance lens).		
Fees charged by your immediate relatives or members of your household.	✓	
Full-time nursing care in your home	✓	
Hearing aids or exams to fit 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.	✓	
Massage therapy		✓ Covered when ordered as part of physical therapy program in accord with Medicare guidelines.
Naturopath services (uses natural or alternative treatments)	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Nonconventional intraocular lenses (IOLs) following cataract surgery (for example, a presbyopia-correcting IOL)	✓	
Orthopedic shoes		✓ If shoes are part of a leg brace and are included in the cost of the brace, or as described otherwise in the Medical Benefits Chart.
Personal items in your room at a hospital or a skilled nursing facility such as a telephone or a television		✓ Telephones and televisions are provided.
Physical exams and other services (1) required for obtaining or maintaining employment or participation in employee programs, (2) required for insurance or licensing, or (3) on court order or required for parole or probation		✓ Covered if a network physician determines that the services are medically necessary or medically appropriate preventive care.
Private duty nursing	✓	
Private room in a hospital		✓ Covered when medically necessary.
Psychological testing for ability, aptitude, intelligence, or interest	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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. Refer to your FEHB Brochure (RI 73-889) for additional coverage.
Reversal of sterilization procedures and non-prescription contraceptive supplies	✓	
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines (for example, if you have diabetes).
Routine hearing exams	✓	
Services considered not reasonable and necessary, according to the standards of Original Medicare		✓ This exclusion doesn't apply to services or items that aren't covered by Original Medicare but are covered by our plan.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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	✓	
Supportive devices for the feet		✓ Orthopedic or therapeutic footwear as described otherwise in the Medical Benefits Chart.
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	✓	✓ This exclusion does not apply to members of the High Option Senior Advantage 1 plan (see "Transportation services" in the Medical Benefits Chart).

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
to travel to a network provider		
Travel and lodging expenses		✓ We may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines.

Section 3.2 – Additional chiropractic services exclusions

The items and services listed in this "Additional chiropractic services exclusions" section are excluded from coverage. These exclusions apply to all services that would otherwise be covered in Section 2.2, "Additional chiropractic services," regardless of whether the services are within the scope of a provider's license or certificate:

- Services provided by a chiropractor that are not within the scope of licensure for a chiropractor licensed in California.
- Adjunctive therapy not associated with spinal, muscle, or joint manipulations.
- Air conditioners, air purifiers, therapeutic mattresses, chiropractic appliances, durable medical equipment, supplies, devices, appliances, and any other item except those listed as covered under "Chiropractic supports and appliances" in Section 2.2, "Additional chiropractic services."
- Services for asthma or addiction, such as nicotine addiction.
- Hypnotherapy, behavior training, sleep therapy, and weight programs.
- Thermography.
- Experimental or investigational services. If coverage for a service is denied because it is experimental or investigational and you want to appeal the denial, refer to Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)."
- CT scans, MRIs, PET scans, bone scans, nuclear medicine, and any other type of diagnostic imaging or radiology other than X-rays covered under "Laboratory tests and x-rays" in Section 2.2, "Additional chiropractic services."
- Ambulance and other transportation.
- Education programs, non-medical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing.
- Services for pre-employment physicals or vocational rehabilitation.
- Drugs and medicines, including non-legend or proprietary drugs and medicines.

- Services you receive outside the state of California, except for services covered under "Emergency and urgent services" in the "Covered services" in Section 2.2, "Additional chiropractic services."
- Hospital services, anesthesia, manipulation under anesthesia, and related services.
- Dietary and nutritional supplements, such as vitamins, minerals, herbs, herbal products, injectable supplements, and similar products.
- Massage therapy.
- Maintenance care (services provided to members whose treatment records indicate that they have reached maximum therapeutic benefit).

Section 3.3 – DeltaCare USA limitations and exclusions for members enrolled in the High Option Senior Advantage 1 or Standard Option Senior Advantage plans

DeltaCare USA limitations

The following services and items are limited under your DeltaCare USA dental benefit:

1. Full mouth x-rays are limited to one set every 36 consecutive months and include any combination of periapicals, bitewings and/or panoramic film.
2. Bitewing x-rays are limited to not more than one series of four films in any 6-month period.
3. Diagnostic casts are limited to aid in diagnosis by the DeltaCare USA dentist for covered benefits.
4. If a biopsy is preauthorized by Delta Dental for an oral surgeon, then examination of the resulting biopsy specimen is covered under codes D0472, D0473, or D0474 and available at no additional cost.
5. Prophylaxis or periodontal maintenance is limited to one procedure each 6-month period.
6. A filling is a benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.
7. A crown is a benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the 5-year limitation (limitation #11).
8. A covered metallic inlay or onlay using base or noble metal is available for listed Copayment(s). If you elect to have high noble metal used instead, the maximum additional cost of this material upgrade is $100 per tooth. For an indirectly fabricated post and core, the benefit is for base or noble metal. If you elect to have a high noble metal indirectly fabricated post and core instead, the maximum additional cost of this material upgrade is $100 per tooth.
9. For molars, a covered crown or unit of a fixed partial denture (bridge) is a full cast metal restoration without porcelain or other tooth-colored material. If the Enrollee elects to have porcelain, porcelain-fused-to-metal, resin, or resin-with-metal used instead, the maximum additional cost for this tooth-colored material upgrade is $75 per molar.

10. If a porcelain margin is also chosen by the Enrollee for a covered porcelain-fused-to-metal crown, the maximum additional cost for this laboratory upgrade is $75.
11. The replacement of an existing inlay, only, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:
    - the existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, **and**
    - either of the following:
        a) the existing non-functional restoration/bridge/denture was placed five or more years prior to its replacement, **or**
        b) if an existing partial denture is less than five years old, but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.
12. A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the DeltaCare USA dentist is not performing root canal therapy.
13. Periodontal scaling and root planning are limited to four quadrants during any 12-month period.
14. Full mouth debridement (gross scale) is limited to one treatment in any 12-month period.
15. The benefit for the replacement of a missing posterior tooth (or teeth) is a removable partial denture. Coverage for the placement of a fixed partial denture (bridge) is optional except in the following cases:
    - the sole tooth to be replaced in the arch is a permanent anterior tooth, provided that it is not in conjunction with a partial denture on the same arch. A cantilever bridge is a benefit at the professional discretion of the DeltaCare USA dentist for the replacement of one missing permanent anterior tooth only; **or**
    - the new bridge would replace an existing, non-functional bridge utilizing the same abutment teeth, with no additional abutments or pontics with the exception of posterior cantilever bridges (see limitation #11).
    - the abutment teeth are not being crowned solely for the purpose of supporting a pontic (each abutment tooth to be crowned must meet limitation #7).
16. Relines, tissue conditioning, and rebases are limited to one per denture during any 12 consecutive months.
17. Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to:
    - the replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture.
18. Excision of the frenum is a benefit only when it results in limited mobility of the tongue, it causes a large diastema between teeth or it interferes with a prosthetic appliance.
19. In cases of accidental injury, benefits available are described above in the medical benefits chart under Accident Injury Benefit. Damages to the hard and soft tissues of the oral cavity

from normal masticatory (chewing) function, exclusive attrition and normal wear, will be covered as described in the dental benefit chart and limitations and exclusions of benefits.

20. Benefits for a soft tissue management program are limited to those parts, which are listed as covered services in Section 2.4 of this chapter. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered benefits.
21. A new removable partial, complete or immediate denture includes after delivery adjustment and tissue conditioning at no additional cost for the first 6 months after placement if the Enrollee continues to be eligible and the service is provided at the DeltaCare USA facility where the denture was originally delivered.
22. An Optional procedure is defined as any alternative procedure presented by the DeltaCare USA dentist that satisfies the same dental need as a covered procedure, is chosen by the member, and is subject to the limitations and exclusions of the program. The applicable charge to the member is the difference between the DeltaCare USA dentist's "filed fees" for the Optional procedure and the "filed fees" for the covered procedure, plus any applicable Copayment for the covered procedure. Optional treatment does not apply when alternative choices are benefits. Optional procedures include:
    - the use of a tooth-colored material when restoring a posterior tooth with a filling, inlay or onlay; and
    - units in a fixed partial denture (bridge) made of porcelain/ceramic, which is not fused to and supported by underlying cast metal.

"Filed fees" means the DeltaCare USA dentist's fees on file with Delta Dental. Questions regarding these fees should be directed to Delta Dental's Customer Service department at **1-800-422-4234**.

DeltaCare USA exclusions

The following services and items are not covered under your DeltaCare USA dental benefit.

1. Any procedure that is not specifically listed in Section 2.4.
2. Dental conditions arising out of and due to Enrollee's employment for which Workers' Compensation is paid. Services which are provided to the Enrollee by state government or agency thereof, or are provided without cost to the Enrollee by any municipality, county or other subdivision, except as provided in Section 1373(a) of the California Health and Safety Code.
3. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
4. Loss or theft of full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
5. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.

6. Dental expenses incurred in connection with any dental procedure started before the Enrollee's eligibility with the DeltaCare USA program. Examples include: teeth prepared for crowns, root canals in progress, orthodontics.
7. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.).
8. Dispensing of drugs not normally utilized in the delivery of dental services.
9. Any procedure that in the professional opinion of the DeltaCare USA dentist:
   - has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   - is inconsistent with generally accepted standards for dentistry.
10. Dental services received from any dental facility other than the assigned DeltaCare USA dentist including the services of a dental specialist, unless expressly authorized in writing by Delta Dental or as cited under *Emergency Services.* To obtain written authorization, the Enrollee should call Delta Dental's Customer Service department at **1-800-422-4234**.
11. Consultations for non-covered benefits.
12. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.
13. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth or the anticipation of future fractures.
14. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ).
15. An initial treatment plan which involves the removal and reestablishment of the occlusal contacts of 10 or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combination of these is considered to be full mouth reconstruction under the DeltaCare USA program. Crowns, onlays and fixed partial dentures associated with such a treatment plan are not covered benefits. This exclusion does not eliminate the benefit for other covered services.
16. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
17. Extraction of teeth, when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars and orthodontic extractions.
18. Treatment or extraction of primary teeth.
19. A Maryland bridge is considered a specialized technique and is not a benefit. Recementation, repair or replacement of an existing Maryland bridge is not a benefit.

DeltaCare USA Accident Injury benefit limitations and exclusions

Limitations: Accident injury benefits are limited to services provided as a result of an accident which occurred (a) while the Enrollee was covered under the DeltaCare USA program, or (b) while the Enrollee was covered under another DeltaCare USA program, and if the benefits for the expenses incurred would have been paid if the Enrollee had remained covered under that program.

Exclusions: In addition to the above listed limitations and exclusions (limitations #12, #17, and #19 and exclusions #1-9, #11-14 and #17-19), the following exclusions apply:

1. Prophylaxis.
2. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
3. Replacement of existing restorations due to decay.
4. Orthodontic services (treatment of malalignment of teeth and/or jaws).
5. Replacement of existing restorations, crowns, bridges, dentures and other dental or orthodontic appliances damaged by accident injury.

"Filed fees" means the DeltaCare USA dentist's fees on file with Delta Dental. Questions regarding these fees should be directed to Delta Dental's Customer Service department at **1-800-422-4234**.

Section 3.4 – Travel benefit exclusions

The following are a few examples of services not included in your travel benefit coverage:

- Nonemergency hospitalization.
- Infertility treatments.
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.
- Durable medical equipment (DME).
- Prescription drugs.
- Home health services.

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

? **Did you know there are programs to help people pay for their drugs?**
The "Extra Help" program helps people with limited resources pay for their drugs. For more information, see Chapter 2, Section 7.

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." Phone numbers for Member Services are printed on the back cover of this booklet.

Section 1 — Introduction

Section 1.1 – This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The next chapter tells you what you pay for Part D drugs (Chapter 6, "What you pay for your Part D prescription drugs").

In addition to your coverage for Part D drugs, we also cover some drugs under our plan's medical or prescription drug benefits. Through our coverage of Medicare Part A benefits, we generally cover drugs you are given during covered stays in the hospital or in a skilled nursing facility. Through our coverage of Medicare Part B benefits, we cover drugs including certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4, "Medical Benefits Chart (what is covered and what you pay)," tells you about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay, as well as your benefits and costs for Part B drugs. We cover some non-Medicare drugs such as episodic drugs prescribed for the treatment of sexual dysfunction disorders. Chapter 4, "Medical Benefits Chart (what is covered and what you pay)," tells you about the benefits and costs for non-Medicare drugs.

For members with Parts A & B, your drugs may be covered by Original Medicare if you are in Medicare hospice. We only cover Medicare Parts A, B, and D services and drugs that are unrelated to your terminal prognosis and related conditions, and therefore not covered under the Medicare hospice benefit. For more information, please see Section 9.4 in this chapter, "What if you're in Medicare-certified hospice." For information on hospice coverage, see the hospice section of Chapter 4, "Medical Benefits Chart (what is covered and what you pay)."

The following sections discuss coverage of your drugs under our plan's Part D benefit rules. Section 9 in this chapter, "Part D drug coverage in special situations," includes more information about your Part D coverage and Original Medicare.

Section 1.2 – 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 your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You generally must use a network pharmacy to fill your prescription. (See Section 2 in this chapter, "Fill your prescriptions at a network pharmacy or through our mail-order service.")
- Your drug must be on our **2022 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 – To have your prescription covered, 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 covered on our plan's Drug List.

Section 2.2 – Finding 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)**, or call Member Services (phone numbers are printed on the back cover of this booklet). 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 network pharmacy in your area, you can get help from Member Services (phone numbers are printed on the back cover of this booklet) or use the **Pharmacy Directory**. You can also find information on our website at **kp.org/directory**.

What if you need a specialized pharmacy?

Sometimes 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 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, which is typically the pharmacy that the LTC facility uses. 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 (phone numbers are printed on the back cover of this booklet).

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 mail-order service allows you to order up to a 100-day supply.

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

- Register and order online securely at **kp.org/refill**.
- Call **1-888-218-6245** (TTY **711**), Monday through Friday, 8 a.m. to 8 p.m., Saturday 8 a.m. to 6 p.m., and Sunday 9 a.m. to 6 p.m., or the highlighted number listed on your prescription label and follow the prompts. Be sure to select the mail delivery option when prompted.
- Mail your prescription or refill request on a mail-order form available at any Kaiser Permanente network pharmacy.

When you order refills for home delivery online, by phone, or in writing, you must pay your cost-sharing when you place your order (there are no shipping charges for regular USPS mail delivery). If you prefer, you may designate a network pharmacy where you want to pick up and pay for your prescription. 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 get to you in no more than 5 days. If your mail-order prescription is delayed, please call the number listed above or on your prescription bottle's label for assistance. Also, if you cannot wait for your prescription to arrive from our mail-order pharmacy, you can get an urgent supply by calling your local network retail pharmacy listed in your **Pharmacy Directory** or at **kp.org/directory**. Please be aware that you may pay more if you get a 100-day supply from a network retail pharmacy instead of from our mail-order pharmacy if you are enrolled in the High Option Senior Advantage 2 or Standard Option Senior Advantage plans.

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

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. When you place your order, please provide your current contact information in case we need to reach you.

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. You may order this supply through mail-order (see Section 2.3 in this chapter) or you may go to a retail pharmacy.

- 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 (phone numbers are printed on the back cover of this booklet).
- For certain kinds of drugs, you can use our plan's network mail-order services. The drugs available through our mail-order service are marked as "**mail-order**" drugs on our Drug List. Our mail-order service allows you to order up to a 100-day supply. See Section 2.3 in this chapter for more information about using our mail-order services.

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. If you cannot use a 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.

In these situations, please check first with Member Services to see if there is a network pharmacy nearby. Phone numbers for Member Services are printed on the back cover of this booklet. You may 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.

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 share of the cost) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1, 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 **2022 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 must meet requirements set by Medicare. Medicare has approved our plan's Drug List.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

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. (That is, the Food and Drug Administration has approved the drug 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 both brand-name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. Generally, it works just as well as the brand-name drug and usually costs less. There are generic drug substitutes available for many brand-name drugs.

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.

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

Every drug on our plan's Drug List is in one of **four** cost-sharing tiers. Preferred generic and generic drugs listed in the formulary will be subject to the generic drug cost-sharing, and preferred and nonpreferred brand-name drugs listed in the formulary will be subject to the brand-name cost-sharing. You will pay the applicable cost-sharing depending upon the tier the drug is in:

- Cost-sharing for generic drugs.
- Cost-sharing for brand-name drugs.
- Cost-sharing for specialty-tier drugs (this tier includes both generic and brand-name drugs).
- Cost-sharing 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 in each cost-sharing tier is shown in Chapter 6 ("What you pay for your Part D prescription drugs").

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 **kp.org**.
- Visit our website (**kp.org/seniorrx**). Our Drug List (**2022 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 **(2022 Comprehensive Formulary**) or to ask for a copy of the list. Phone numbers for Member Services are printed on the back cover of this booklet.

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 we cover them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever 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. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

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. 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, Section 6.2, for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once on our Drug List (**2022 Comprehensive Formulary**). This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 – What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

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. We usually will not cover the brand-name drug when a generic version is available. 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." Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by our plan.

Section 4.3 – Do any of these restrictions apply to your drugs?

Our plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check our Drug List. For the most up-to-date information, call Member Services (phone numbers are printed on the back cover of this booklet) or check our website (**kp.org/seniorrx**).

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. If there is a restriction on the drug you want to take, you should 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, Section 6.2, for information about asking for exceptions.)

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

We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently 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 of this chapter, some of the drugs covered by our plan have extra rules to restrict their use. In some cases, you may want us to waive the restriction for you.
- 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. Our plan puts each covered drug into one of four different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend upon what type of problem you have:
  - 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 things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- 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, we must offer a temporary supply of a drug to you when your drug is not on our Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is no longer on our plan's Drug List.
- Or the drug you have been taking is now restricted in some way (Section 4 in this chapter tells you about restrictions).

2. You must be in one of the situations described below:

- **For those members who are new or who were in our plan last year: We** will cover a temporary supply of your drug during the first 90 days of your membership in our plan if you are new and during the first 90 days of the calendar year if you were in our plan last 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 (LTC) facility and need a supply right away:** We will cover one 31-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply situation.
- **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.

To ask for a temporary supply, call Member Services (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by our plan or ask us to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by our plan that might 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. Phone numbers for Member Services are printed on the back cover of this booklet.

You can ask for an exception

You and your provider can ask us to make an exception for you and cover the drug in the way you would like it to be 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 to the rule. 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, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might 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. Phone numbers for Member Services are printed on the back cover of this booklet.

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 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 might make changes to the Drug List. For example, we might:

- Add or remove drugs from the Drug List. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- Move a drug to a higher or lower cost-sharing tier.
- Add or remove a restriction on coverage for a drug (for more information about restrictions to coverage, see Section 4 in this chapter).
- 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 during the year, we post information on our website about those changes. We will update our online Drug List on a regularly scheduled basis to include any changes that have occurred after the last update. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).

Do changes to your drug coverage affect you right away?

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current 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 that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, 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.
  - We may not tell you in advance before we make that change—even if you are currently taking the brand-name drug.
  - 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, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)."
  - 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) we made. 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.
- Unsafe drugs and other drugs on the Drug List that are withdrawn from the market.
  - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change 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 instance, we might add a generic drug that is not new to the market to replace a brand-name drug 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. 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 be working with your prescriber to switch to a different drug that we cover.
- ♦ Or 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, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)."

Changes to drugs on the Drug List that will not affect people currently taking the drug
For changes to the Drug List that are not described above, if you are currently taking the drug, the following types of changes will not affect you until January 1 of the next year if you stay in our plan:

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

If any of these changes happen to a drug you are taking (but not because of a 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 restriction to your use of the drug. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the Drug List in the new benefit year for any changes to drugs.

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. We won't pay for the drugs that are listed in this section; except for certain excluded drugs covered under our enhanced drug coverage and if the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5, in this booklet.)

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 and 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.
  - ♦ Generally, 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. If the use is not supported by any of these references, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans. Our plan covers certain drugs listed below through our enhanced drug coverage. More information is provided below:

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

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 booklet.)

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 our Member Service Contact Center for more information.) However, if you have drug coverage through Medicaid, 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 — Show your plan membership card when you fill a prescription

Section 8.1 – Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill our plan for our share of your covered prescription 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 card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to 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 2.1, 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 our plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, we will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell you about the rules for getting drug coverage. Chapter 6 ("What you pay for your Part D prescription drugs") gives you more information about drug coverage and what you pay.

Please note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage. (Chapter 10, "Ending your membership in our plan," tells you when you can leave our plan and join a different Medicare plan.)

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 a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your **Pharmacy Directory** to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services (phone numbers are printed on the back cover of this booklet).

What if you're a resident in a long-term care (LTC) facility and become a new member of our plan?

If you need a drug that is not on our Drug List or is restricted in some way, we will cover a temporary supply of your drug during the first 90 days of your membership. The total supply will be for a maximum of up to a 31-day supply, or less if your prescription is written for fewer days. (Please note that the long-term care (LTC) pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

If you have been a member of our plan for more than 90 days and need a drug that is not on our Drug List or if our plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by our plan that might work just as well for you. Or you and your provider can ask us to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 6.4, tells you what to do.

Section 9.3 – Special note about "creditable coverage"

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

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 these notices about creditable coverage because you may need them 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 a notice about creditable coverage, you can get a copy by calling Member Services.

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

Except for Part B Only plan members whose hospice care is covered by our plan, drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication, or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this chapter that tell about the rules for getting drug coverage under Part D. Chapter 6, "What you pay for your Part D prescription drugs," gives more information about drug coverage and what you pay.

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. These reviews are especially important for members who have more than one provider who prescribes their drugs.

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 medical 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 written 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 can help make sure our members safely use their prescription opioid medications, and other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, 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. 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 think that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the limitations we think should apply to you. You will also 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 that you are at-risk for prescription drug misuse or with the limitation, you and your prescriber have the right to ask us for an appeal. If you choose to 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.

The DMP may not apply to you if you have certain medical conditions, such as cancer, or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or you 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.

This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us. This program can help make sure that our members get the most benefit from the drugs they take.

Our program is called a Medication Therapy Management (MTM) program. 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. You can talk about how best to take 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 of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking 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 have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list 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 from the program. If you have any questions about these programs, please contact Member Services (phone numbers are printed on the back cover of this booklet).

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

? **Did you know there are programs to help people pay for their drugs?**
The "Extra Help" program helps people with limited resources pay for their drugs. For more information, see Chapter 2, Section 7.

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." Phone numbers for Member Services are printed on the back cover of this booklet.

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 your 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 are covered under your FEHB plan.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **Our 2022 Comprehensive Formulary.** To keep things simple, we call this the "Drug List."
  - This Drug List tells you which drugs are covered for you.
  - It also tells you which of the four "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call Member Services (phone numbers are printed on the back cover of this booklet). You can also find the Drug List on our website at **kp.org/seniorrx**. The Drug List on the website is always the most current.
- **Chapter 5 of this booklet.** Chapter 5 gives you the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells you which types of prescription drugs are not covered by our plan.
- **Our plan's Pharmacy Directory.** In most situations, you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The **Pharmacy Directory** has a list of pharmacies in our plan's network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month supply).

- This chapter describes our Medicare Part D prescription drug coverage for the following Senior Advantage plans for Federal Members in our Northern California Region's Fresno service area:
  - ♦ High Option Senior Advantage 1 plan.
  - ♦ High Option Senior Advantage 2 plan.
  - ♦ Standard Option Senior Advantage plan.

If you are not certain which plan you are enrolled in, please call Member Services.

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

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. 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 must pay for drugs before our plan begins to pay its share.
- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

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?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under our plan. How much you pay for a drug depends upon which of these stages you are in at the time you get a prescription filled or refilled.

Stage 1	Stage 2	Stage 3	Stage 4
Yearly Deductible Stage Because there is no deductible for our plan, this payment stage does not apply to you.	**Initial Coverage Stage** You begin in this stage when you fill your first prescription of the year. During this stage, we pay our share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your year-to-date "out of pocket costs"	**Coverage Gap Stage** Because there is no coverage gap for our plan, this payment stage **does not apply** to you.	**Catastrophic Coverage Stage** During this stage, we will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2022).

Stage 1	Stage 2	Stage 3	Stage 4
	(your payments) total **$7,050**. (Details are in Section 5 of this chapter.)		(Details are in Section 7 of this chapter.)

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.

Our plan will prepare a written summary called the **Part D Explanation of Benefits** (it is sometimes called the **"Part D EOB"**) when you have had one or more prescriptions filled through our plan during the previous month. The **Part D EOB** provides more information about the drugs you take, such as increases in price and other drugs with lower cost-sharing that may be available. You should consult with your prescriber about these lower-cost options. 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 any percentage change from first fill for each prescription claim of the same quantity.
- **Available lower-cost alternative prescriptions.** This will include information about other drugs with lower cost-sharing for each prescription claim that may be available.

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 when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when 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, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask us to pay our share of the cost. For instructions about how to do this, go to Chapter 7, Section 2, of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  - 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.
- **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 and help qualify you for catastrophic coverage. 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. You should 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 Explanation of Benefits** (a **Part D EOB**) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). 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. They are an important record of your drug expenses.

Section 4 — There is no deductible for Senior Advantage

Section 4.1 – You do not pay a deductible for your Part D drugs

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 four cost-sharing tiers

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

- Cost-sharing for generic drugs.
- Cost-sharing for brand-name drugs.
- Cost-sharing for specialty-tier drugs (this tier includes both generic and brand-name drugs).
- Cost-sharing 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.

Note: Preferred generic and generic drugs listed in the formulary will be subject to the generic drug cost-sharing, and preferred and nonpreferred brand-name drugs listed in the formulary will be subject to the brand-name cost-sharing.

Your pharmacy choices

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

- A retail pharmacy that is in our plan's network.
- A pharmacy that is not in our plan's network.
- Our plan's mail-order pharmacy.

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

Section 5.2 – A table that shows 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.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends upon which cost-sharing tier your drug is in. **Please note:**

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5, for information about when we will cover a prescription filled at an out-of-network pharmacy.

Your share of the cost when you get a one-month supply of a covered Part D prescription drug:

Cost-sharing tier	**Retail cost-sharing (in-network)**	**Mail-order cost-sharing**	**Long-term care (LTC) cost-sharing**	**Out-of-network cost-sharing** (Coverage is limited to certain situations; see Chapter 5 for details)
	(up to a 30-day supply)		(up to a 31-day supply)	(up to a 30-day supply)
Generic drugs	**$10**			
Brand-name drugs				
• High Option Senior Advantage 1 plan	**$30**			
• High Option Senior Advantage 2 and Standard Option Senior Advantage plans	**$40**			
Specialty drugs				
• High Option Senior Advantage 1 and High Option Senior Advantage 2 plans	**$100**			
• Standard Option Senior Advantage 1 plan	**$150**			

Cost-sharing tier	**Retail cost-sharing (in-network)**	**Mail-order cost-sharing**	**Long-term care (LTC) cost-sharing**	**Out-of-network cost-sharing** (Coverage is limited to certain situations; see Chapter 5 for details)
	(up to a 30-day supply)		(up to a 31-day supply)	(up to a 30-day supply)
Injectable Part D vaccines (all plans)	**$0**	Mail-order isn't available.	**$0**	

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 of a covered drug. However, your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month's supply, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the amount you pay will be less.
- If you are responsible for a copayment for the drug, your copayment will be based on the number of days of the drug that you receive. 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.
  - Here's an example: Let's say the copayment for your drug for a full month's supply (a 30-day supply) is $30. This means that the amount you pay per day for your drug is $1. If you receive a 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan refill

dates for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days' supply you receive.

Section 5.4 – A table that shows your costs for a long-term (up to a 100-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 100-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5, Section 2.4.)

The table below shows what you pay when you get a long-term (up to a 100-day) supply of a drug.

- **Please note:** If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.

Your share of the cost when you get a long-term supply of a covered Part D prescription drug:

Cost-sharing tier	Retail cost-sharing (in-network)	Mail-order cost-sharing
	(up to a 100-day supply)	
Generic drugs		
• High Option Senior Advantage 1 plan	**$10**	**$10**
• High Option Senior Advantage 2 and Standard Option Senior Advantage plans	**$30**	**$20**
Brand-name drugs		
• High Option Senior Advantage 1 plan	**$30**	**$30**
• High Option Senior Advantage 2 and Standard Option Senior Advantage plans	**$120**	**$80**
Specialty drugs		
• High Option Senior Advantage 1 plan	**$100**	**$100**
• High Option Senior Advantage 2 plan	**$300**	**$200**
• Standard Option Senior Advantage plan	**$450**	**$300**
Injectable Part D vaccines (all plans)	A long-term supply isn't available.	

Section 5.5 – You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $7,050

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach **$7,050**. Medicare has rules about what counts and what does not count as your out-of-pocket costs. (See Section 5.6 for information about how Medicare counts your out-of-pocket costs.) When you reach an out-of-pocket limit of $7,050, you leave the Initial Coverage Stage and 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 total out-of-pocket costs. To find out which drugs our plan covers, refer to your formulary.

The **Part D Explanation of Benefits** (**Part D EOB**) that we send to you will help you keep track of how much you and our plan, as well as any third parties, have spent on your behalf during the year. Many people do not reach the **$7,050** limit in a year.

We will let you know if you reach this **$7,050** amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

Section 5.6 – How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

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

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

- 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.

Moving on to the Catastrophic Coverage Stage:
When you (or those paying on your behalf) have spent a total of **$7,050** 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

When you add up your out-of-pocket costs, you are not allowed to include any of these types of payments for prescription drugs:

- Your FEHB contribution amount.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet our plan's requirements for out-of-network coverage.
- Non–Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare, covered under our additional coverage.
- Payments for your drugs that are made or funded by group health plans, including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs, such as TRICARE and Veterans Affairs.
- Payments for your drugs made by a third party with a legal obligation to pay for prescription costs (for example, workers' compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are printed on the back cover of this booklet).

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

- **We will help you.** The **Part D Explanation of Benefits** (**Part D EOB**) summary we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells you about this report). When you reach a total of **$7,050** in out-of-pocket costs for the year, 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 in this chapter tells you what you can do to help make sure that our records of what you have spent are complete and up-to-date.

Section 6 — There is no coverage gap for our plan

Section 6.1 – You do not have a coverage gap for your Part D drugs

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 for information about your coverage in the Catastrophic Coverage Stage.

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

Section 7.1 – Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the **$7,050** 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. During this stage, we will pay most of the cost for your drugs.

You will pay **$3** for covered generic drugs (includes drugs treated like generics). You will pay **$10** for covered brand-name drugs, **$13** for covered specialty-tier drugs, and **$0** for covered injectable Part D vaccines. We will pay the rest.

Section 8 — What you pay for vaccinations covered by Part D depends upon how and where you get them

Section 8.1 – Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

We provide coverage for a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Medical Benefits Chart in Chapter 4, Section 2.1.

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

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

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends upon three things:

- **The type of vaccine** (what you are being vaccinated for).
  - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to Chapter 4, "Medical Benefits Chart (what is covered and what you pay)."
  - Other vaccines are considered Part D drugs. You can find these vaccines listed in our **2022 Comprehensive Formulary**.
- **Where you get the vaccine medication.**

- **Who gives you the vaccine.** What you pay at the time you get the Part D vaccination can vary depending upon the circumstances. For example:
  - Sometimes when you get your vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. You can ask us to pay you back for our share of the cost.
  - Other times, when you get the vaccine medication or the vaccine, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccine.

- Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccine at the network pharmacy. (Whether you have this choice depends upon where you live. Some states do not allow pharmacies to administer a vaccination.)
  - You will have to pay the pharmacy the amount of your copayment for the vaccine and 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 vaccination, you will pay for the entire cost of the vaccine and its administration.
  - You can then ask us to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet ("Asking us to pay our share of a bill you have received for covered medical services or drugs").
  - 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 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 the amount of 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 of this booklet.
  - 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.

Section 8.2 – You may want to call Member Services before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you first call Member Services whenever you are planning to get a vaccination. Phone numbers for Member Services are printed on the back cover of this booklet.

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.

- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

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

Section 1.1 – If you pay our share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment

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

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

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

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

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill our plan for our share of the cost.

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

When a 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 services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-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. For more information about "balance billing," go to Chapter 4, Section 1.3.

- 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. ("Retroactive" means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

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

Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request. Phone numbers for Member Services are printed on the back cover of this booklet.

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

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.5, to learn more.

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

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

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

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

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

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

- For example, the drug may not be on our **2022 Comprehensive Formulary;** or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

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

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 booklet, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," 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

Section 2.1 – How and where to send us your request for payment

Send us your request for payment, along with 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.

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. Phone numbers for Member Services are printed on the back cover of this booklet. 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:
    - o Your name (member/patient name) and medical/health record number.
    - o The date you received the services.
    - o Where you received the services.
    - o Who provided the services.
    - o Why you think we should pay for the services.
    - o 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 of medical care together with any bills or paid receipts to us at this address:

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

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

Kaiser Permanente
CA Medicare PDU/MSU Operations
P.O. Box 1809
Pleasanton, CA 94566

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.

Contact Member Services if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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 for getting the care or drug, 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. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- 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. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

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 you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means

you are asking us to change the decision we made when we turned down your request for payment.

For the details about how to make this appeal, go to Chapter 9 of this booklet, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 9. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives you definitions of terms such as "appeal." Then, after you have read Section 4, you can go to the section in Chapter 9 that tells you what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.5 in Chapter 9.

Section 4 — Other situations in which you should save your receipts and send copies to us

Section 4.1 – In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

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

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

1. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside our plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through our plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

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

Chapter 8 — Your rights and responsibilities

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

Section 1.1 – We must provide information in a way that works for you (in languages other than English, large print, braille, or CD)

To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English-speaking members. This booklet is available in Spanish by calling Member Services (phone numbers are on the back cover of this booklet). We can also give you information in large print, braille, or CD, at no cost if you need it. We are required to give you information about our plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services (phone numbers are printed on the back cover of this booklet). You may also file a complaint with Medicare by calling **1-800-MEDICARE (1-800-633-4227)** or directly with the Office for Civil Rights. Contact information is included in this **Evidence of Coverage** or with this mailing, or you may contact Member Services for additional information.

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

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

Nuestro plan cuenta con personas y servicios de interpretación disponibles sin costo para responder las preguntas de los miembros discapacitados y que no hablan inglés. Este folleto está disponible en español; llame a Servicio a los Miembros (los números de teléfono están en la contraportada de este folleto). Si la necesita, también podemos darle, sin costo, información en letra grande, braille, o CD. Tenemos la obligación de darle información acerca de los beneficios de nuestro plan en un formato que sea accesible y adecuado para usted. Para obtener nuestra información de una forma que se adapte a sus necesidades, por favor llame a Servicio a los Miembros (los números de teléfono están impresos en la contraportada de este folleto).

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

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

As a member of our plan, you have the right to choose a primary care provider (PCP) in our network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). 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.

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

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10, of this booklet tells you what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 4, 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.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practices," that tells you about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- Your health information is shared with your group only with your authorization or as otherwise permitted by law.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information, including information about your Part D prescription

drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations.

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are printed on the back cover of this booklet).

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. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in Spanish, large print, braille, or CD.)

If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about our plan's financial condition. It also includes information about the number of appeals made by members and our plan's star ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers, including our network pharmacies.**
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers in our network, see the **Provider Directory**.
  - For a list of the pharmacies in our network, see the **Pharmacy Directory**.
  - For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at **kp.org/directory**.
- **Information about your coverage and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details about your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus our plan's Drug List. These chapters, together with the Drug List, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.

- If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).

- **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells you about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask us to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.5 – We must treat you with dignity and respect and support your right to make decisions about your care

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

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking a medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells you how to ask us for a coverage decision.

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

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

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

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

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

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms (phone numbers are printed on the back cover of this booklet).
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Quality Improvement Organization listed in Chapter 2, Section 4.

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 or concerns about your covered services or care, Chapter 9 of this booklet tells you what you can do. It gives you the details about how to deal with all types of problems and complaints.

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

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are printed on the back cover of this booklet).

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 or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at **1-800-368-1019** 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 (phone numbers are printed on the back cover of this booklet).
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, 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 users should call **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** (phone numbers are printed on the back cover of this booklet).
- **You can call the SHIP.** For details about this organization and how to contact it, 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 users should call **1-877-486-2048**.

Section 1.9 – Information about new technology assessments

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

Section 1.10 – You can make suggestions about rights and responsibilities

As a member of our plan, you have the right to make recommendations about the rights and responsibilities included in this chapter. Please call Member Services with any suggestions (phone numbers are printed on the back cover of this booklet).

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

Section 2.1 – What are your responsibilities?

Things you need to do as a member of our plan are listed below. If you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this **Evidence of Coverage** booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
  - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "coordination of benefits" because it involves coordinating the health and drug benefits you get from us with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)
- **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 your doctors and other health care providers give you the best care, learn as much as you are able to about your health problems and give them the information they

need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure you understand your health problems and participate in developing mutually agreed upon treatment goals with your providers whenever possible. Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you are responsible for these payments:
  - Paying your Medicare premiums.
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B (or Medicare Part B only). Some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for 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. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells you what you must pay for your medical services. Chapter 6 tells you what you must pay for your Part D prescription drugs.
  - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
  - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of our plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).
  - If you move outside of your plan's service area, you cannot remain a member of our plan. (Chapter 1 tells you about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a special enrollment period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - If you move within your plan's service area, we still need to know so we can keep your membership record up-to-date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.

- Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
- For more information about how to reach us, including our mailing address, please see Chapter 2.

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

Coverage decisions and appeals

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

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by you and us.

Which one do you use?

That depends upon the type of problem you are having. The guide in Section 3 of this chapter will help you identify the right process to use.

Other dispute resolution options

As an FEHB member, you also have additional dispute resolution rights and a different appeals process through the FEHB Program. For a complete statement of your benefits and rights under the FEHB Program, please read your FEHB brochure (RI 73-889). All FEHB Program benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB brochure.
Note: If you have an issue relating to coverage of a benefit that is not covered by Medicare, but is covered under your FEHB membership, please refer to your FEHB brochure for dispute resolution options because the Medicare appeal process does not apply.

Section 1.2 – What about the legal terms?

There are technical 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 keep things simple, this chapter explains the legal rules and procedures using 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 for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. 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 — You can get help from government organizations that are not connected with us

Section 2.1 – Where to get more information and personalized assistance

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

Get help from an independent government organization

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

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

You can also get help and information from Medicare

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

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

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

Section 3.1 – Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

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

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

Is your problem or concern about your benefits or coverage?

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

- **Yes, my problem is about benefits or coverage:**
  - Go to the next section in this chapter, Section 4: "A guide to the basics of coverage decisions and appeals."
- **No, my problem is not about benefits or coverage:**
  - 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

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

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your 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 and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules

properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision. In limited circumstances an appeal request 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 an appeal request, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

Section 4.2 – How to get help when you are asking for a coverage decision or making an appeal

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

- You **can call Member Services** (phone numbers are printed on the back cover of this booklet).
- You **can get free help** from your **State Health Insurance Assistance Program** (see Section 2 in this chapter).
- **Your doctor can make a request for you.**
  - For medical care or Medicare Part B prescription drugs, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under state law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) 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.

- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision.

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

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

- **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 to these services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services).

If you're not sure which section you should be using, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your SHIP (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

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

? Have you read Section 4 in this chapter ("A guide to the basics of coverage decisions and appeals")? If not, you may want to read it before you start this section.

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 Chapter 4 of this booklet: "Medical Benefits Chart (what is covered and what you pay)." To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time. The term "medical care" includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Medicare Part B prescription drug.

In those cases, we will explain how the rules for Medicare Part B prescription drugs are different from the rules for medical items and services.

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

- You are not getting certain medical care you want, and you believe that this care is covered by our plan.
- We will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by our plan.
- You have received medical care that you believe should be covered by our plan, but we have said we will not pay for this care.
- You have received and paid for medical care that you believe should be covered by our plan, and you want to ask us to reimburse you for this care.
- You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:

- **Section 7** of 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** of this chapter**:** "How to ask us to keep covering certain medical services if you think your coverage is ending too soon." This section is about three services only: home health care, skilled nursing facility care, and CORF services.

For all other situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
To find out whether we will cover the medical care you want.	You can ask us to make a coverage decision for you. Go to the next section in this chapter, **Section 5.2**.
If we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 5.3** in this chapter.

If you want to ask us to pay you back for medical care you have already received and paid for.	You can send us the bill. Skip ahead to **Section 5.5** in this chapter.

Section 5.2 – Step-by-step: How to ask for a coverage decision (how to ask us to authorize or provide the medical care coverage you want)

Legal Terms	When a coverage decision involves your medical care, it is called an **"organization determination."**

Step 1: You ask us to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a "fast coverage decision."

Legal Terms	A **"fast coverage decision"** is called an **"expedited determination."**

How to request coverage for the medical care you want

- Start by calling, writing, or faxing us to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details about how to contact us, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care."

Generally we use the standard deadlines for giving you our decision
When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer **within 14 calendar days** after we receive your request for a medical item or service. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** after we receive your request.

- However, for a request for a medical item or service, we can take up to 14 more calendar days if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint **within 24 hours**. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)

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

- A fast coverage decision means we will answer **within 72 hours** if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours.**
  - However, for a request for a medical item or service, we can take up to 14 more calendar days if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision only if you are asking for coverage for medical care you have not yet received. (You cannot ask for a fast coverage decision if your request is about payment for medical care you have already received.)
  - You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.
- If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)

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

Deadlines for a "fast coverage decision"

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint **within 24 hours.** (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)
- If we do not give you our answer **within 72 hours** (or if there is an extended time period, by the end of that period), or **within 24 hours** if your request is for a Medicare Part B prescription drug, you have the right to appeal. Section 5.3 below tells you how to make an appeal.

- **If our answer is no to part or all of what you requested,** we will send you a detailed written explanation as to why we said no.

Deadlines for a "standard coverage decision"

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days** of receiving your request. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
  - For a request for a medical item or service, we can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint **within 24 hours**. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)
  - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or within 72 hours if your request is for a Medicare Part B prescription drug, you have the right to appeal. Section 5.3 below tells you how to make an 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.

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

- If we say **no,** you have the right to ask us to reconsider, and perhaps change this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 – Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms	An appeal to our plan about a medical care coverage decision is called a plan **"reconsideration."**

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

What to do

- **To start an appeal, you, your doctor, or your representative must contact us**. For details about how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care."
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.**
  - If you have someone appealing our decision for you other than your doctor, your appeal must include an "Appointment of Representative" form authorizing this person to represent you. To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It 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**. While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1, "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care."
- **You must make your appeal request within 60 calendar days from the date on the written notice** we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor may give us additional information to support your appeal.

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

Legal Terms	A **"fast appeal"** is also called an **"expedited reconsideration."**

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

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

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

Deadlines for a "fast appeal"

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

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.

- ♦ However, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more calendar days if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- ♦ If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint **within 24 hours**. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)
- ♦ If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.

- If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within **30 calendar days** if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- If our answer is no to part or all of what you requested, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

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

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

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

If we say no to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the **"Independent Review Organization"** is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: The Independent Review Organization reviews your appeal.

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

- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

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

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

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

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

Step 2: The Independent Review Organization gives you their answer.

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

- If the review organization says yes to part or all of a request for a medical item or service, we must authorize the medical care coverage **within 72 hours** or provide the service **within 14 calendar days** after we receive the decision from the review organization for standard requests or **within 72 hours** from the date we receive the decision from the review organization for expedited requests.
- If the review organization says yes to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug under dispute **within 72 hours** after we receive the decision from the review organization for standard requests or **within 24 hours** from the date we receive the decision from the review organization for expedited requests.
- If this organization says no to part or all of your appeal, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")

- ♦ If the Independent Review Organization "upholds the decision," you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge or attorney adjudicator. Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

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

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: "Asking us to pay our share of a bill you have received for covered medical services or drugs." Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells you how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 in this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service; see Chapter 4, "Medical Benefits Chart (what is covered and what you pay)." We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: "Using our plan's coverage for your medical services").

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying yes to your request for a coverage decision.
- If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the

reasons why in detail. When we turn down your request for payment, it's the same as saying no to your request for a coverage decision.

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

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

To make this appeal, follow the process for appeals that we describe in Section 5.3 of this chapter. Go to this section for step-by-step instructions. When you are following these instructions, **please note:**

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

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

? Have you read Section 4 in this chapter ("A guide to the basics of coverage decisions and appeals")? If not, you may want to read it before you start this section.

Section 6.1 – This section tells what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our **2022 Comprehensive Formulary.** To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3, for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the **2022 Comprehensive Formulary,** rules and restrictions on coverage, and cost information, see Chapter 5 ("Using our plan's coverage for your Part D prescription drugs") and Chapter 6 ("What you pay for your Part D prescription drugs").

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

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

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

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on our **2022 Comprehensive Formulary.**
  - Asking us to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get).
  - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier.
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. For example, when your drug is on our **2022 Comprehensive Formulary,** but we require you to get approval from us before we will cover it for you.
  - **Please note:** If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

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

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

Which of these situations are you in?

If you are in this situation:	This is what you can do:
If you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover.	You can ask us to make an exception. (This is a type of coverage decision.) **Start with Section 6.2 in this chapter.**
If you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need.	You can ask us for a coverage decision. **Skip ahead to Section 6.4 in this chapter.**

If you want to ask us to pay you back for a drug you have already received and paid for.	You can ask us to pay you back. (This is a type of coverage decision.) **Skip ahead to Section 6.4 in this chapter.**
If we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for.	You can make an appeal. (This means you are asking us to reconsider.) **Skip ahead to Section 6.5 in this chapter.**

Section 6.2 – What is an 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. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are 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 2022 Comprehensive Formulary.** (We call it the "Drug List" for short.)

Legal Terms	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."**

   - If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in the brand-name drug tier or generic drug tier. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
2. **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our **2022 Comprehensive Formulary** (for more information, go to Chapter 5, Section 4).

Legal Terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

   - The extra rules and restrictions on coverage for certain drugs include:
     - Being required to use the generic version of a drug instead of the brand-name drug.
     - Getting plan approval in advance before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
   - If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

Legal Terms	Asking to pay a lower price for a covered nonpreferred drug is sometimes called asking for a "**tiering exception**."

- 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). This would lower your share of the cost for the drug.
- You cannot ask us to change the cost-sharing for any specialty drugs.
- If we approve your request for a tiering exception 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 for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 of this chapter tells you how to make an appeal if we say no.

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

Section 6.4 – Step-by-step: How to ask for a coverage decision, including an exception

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

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

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking

for a coverage decision about your Part D prescription drugs." Or if you are asking us to pay you back for a drug, go to the section called "Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received."

- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 in this chapter tells you how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug,** start by reading Chapter 7 of this booklet: "Asking us to pay our share of a bill you have received for covered medical services or drugs." Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells you how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 of this chapter for more information about exception requests.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

Legal Terms	A "fast coverage decision" is called an **"expedited coverage determination."**

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

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

- This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
- The letter will also tell you how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells you how to file a "fast complaint," which means you would get our answer to your complaint **within 24 hours** of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 in this chapter.)

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

Deadlines for a "fast coverage decision"

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

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
  - Generally, this means **within 72 hours** after we receive your request. If you are requesting an exception, we will give you our answer **within 72 hours** after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- If our answer is **yes** to part or all of what you requested:
  - If we approve your request for coverage, we must provide the coverage we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- If our answer is **no** to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

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

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

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

Section 6.5 – Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

Legal Terms	An appeal to our plan about a Part D drug coverage decision is called a plan **"redetermination."**

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

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
  - For details about how to reach us by phone, fax, or mail, or on our website for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are making an appeal about your Part D prescription drugs."
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us** at the phone number shown in Chapter 2, Section 1, "How to contact us when you are making an appeal about your Part D prescription drugs."
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days from the date on the written notice** we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to

make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

Legal Terms	A "fast appeal" is also called an **"expedited redetermination."**

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

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

Deadlines for a "fast appeal"

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

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days after we receive your appeal for a drug you have not received yet.** We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for a "fast appeal."
  - If we do not give you a decision **within 7 calendar days,** we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.

- If our answer is **yes** to part or all of what you requested:
  - If we approve a request for coverage, we must provide the coverage we have agreed to provide as quickly as your health requires, but no later than 7 calendar days after we receive your appeal.
  - If we approve a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive your appeal request.
- If our answer is **no** to part or all of what you requested, we will send you a written statement that explains why we said no and how you can appeal our decision.
- If you are requesting that we pay you back for a drug you have already bought, we must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not give you a decision within 14 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- If our answer is yes to part or all of what you requested, we are also required to make payment to you **within 30 calendar days** after we receive your request.
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal our decision.

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

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.

If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 6.6 – Step-by-step: How to make a Level 2 Appeal

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

Legal Terms	The formal name for the "Independent Review Organization" is **the "Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If we say **no** to your Level 1 Appeal, the written notice we send you will include instructions about how to make a Level 2 Appeal with the Independent Review Organization. These instructions will tell you who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.

- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." You have the right to ask us for a copy of your case file. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.

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

The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.

Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for "fast appeal" at Level 2

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

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.
- If the Independent Review Organization says yes to part or all of what you requested:
  - If the Independent Review Organization approves a request for coverage, we must provide the drug coverage that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to send payment to you **within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

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

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details about how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge or attorney adjudicator. Section 9 in this chapter tells you 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. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: "Medical Benefits Chart (what is covered and what you pay)."

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

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

Section 7.1 – During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered hospital stay, you will be given a written notice called **An Important Message from Medicare about Your Rights.** Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back cover of this booklet). 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**.

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

Legal Terms	The written notice from Medicare tells you how you can **"request an immediate review."** Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 7.2 below tells you how you can request an immediate review.)

- **You will be asked to sign the written notice** to show that you received it and understand your rights.
  - You or someone who is acting on your behalf will be asked to sign the notice. (Section 4 in this chapter tells you how you can give written permission to someone else to act as your representative.)
  - Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice does not mean you are agreeing on a discharge date.
- **Keep your copy of the notice** so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
  - If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
  - To look at a copy of this notice in advance, you can call Member Services (phone numbers are printed on the back cover of this booklet) 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.html.**

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.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 in this chapter).

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

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

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

How can you contact this organization?
The written notice you received **(An Important Message from Medicare About Your Rights)** tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

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.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
  - **If you meet this deadline,** you are allowed to stay in the hospital after your discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - **If you do not meet this deadline,** and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4 of this chapter.

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

Legal Terms	A "fast review" is also called an **"immediate review"** or an **"expedited review."**

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

What happens during this review?

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

Legal Terms	This written explanation is called the **"Detailed Notice of Discharge."** You can get a sample of this notice by calling Member Services (phone numbers are printed on the back cover of this booklet) 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.html.**

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

What happens if the answer is yes?

- If the review organization says yes to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet.)

What happens if the answer is no?

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

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

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

Section 7.3 – Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

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

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

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

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

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

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

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

If the review organization says yes:

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

If the review organization says no:

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an administrative law judge or attorney adjudicator.
- 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?

You can appeal to us instead

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date, whichever comes first.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

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

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

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms	A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

Step 1: Contact us and ask for a "fast review."

- For details about how to contact us, **go to Chapter 2,** Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care."
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

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

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

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

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient

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

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

Step 4: If we say no to your fast appeal, your case will automatically be sent on to the next level of the appeals process.
To make sure we were following all the rules when we said **no** to your fast appeal, we are required to send your appeal to the Independent Review Organization. When we do this, it means that you are automatically going on to Level 2 of the appeals process.

Step-by-step: Level 2 Alternate Appeal Process

During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: We will automatically forward your case to the Independent Review Organization.
We are required to send the information for your Level 2 Appeal to the Independent Review Organization **within 24 hours** of when we tell you that we are saying **no** to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeals process. 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.

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes** to your appeal, then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue our plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says no** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by an administrative law judge or attorney adjudicator.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say **no** to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- 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 about three services only: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is only about the following types of care:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 12, "Definitions of important words.")
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, "Definitions of important words.")

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information about your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: "Medical Benefits Chart (what is covered and what you pay)."

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

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

Legal Terms	In telling you what you can do, the written notice is telling how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 8.3 below tells you how you can request a fast-track appeal.) The written notice is called the **"Notice of Medicare Non-Coverage."**

- You will be asked to sign the written notice to show that you received it.
  - You or someone who is acting on your behalf will be asked to sign the notice. (Section 4 in this chapter tells you how you can give written permission to someone else to act as your representative.)
  - Signing the notice shows only that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with us that it's time to stop getting the care.

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.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 in this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 in this chapter).

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

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

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

How can you contact this organization?
The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?
Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5 of this chapter.

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers inform us of your appeal, you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms	This notice of explanation is called the **"Detailed Explanation of Non-Coverage."**

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

What happens if the reviewers say yes to your appeal?

- If the reviewers say yes to your appeal, then we must keep providing your covered services **for as long as it is medically necessary.**

- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

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

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

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

Section 8.4 – Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

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

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

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

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

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

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

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

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

What happens if the review organization says no?

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

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by 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 in Section 8.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

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

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines. Here are the steps for a Level 1 Alternate Appeal:

Legal Terms	A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

Step 1: Contact us and ask for a "fast review."

For details about how to contact us, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care."

Be sure to ask for a "fast review." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

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

During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending our plan's coverage for services you were receiving.

We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

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

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end, **then you will have to pay the full cost of this care yourself.**

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

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

Step-by-step: Level 2 Alternate Appeal Process

During the Level 2 Appeal, the Independent Review Organization reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

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

We are required to send the information for your Level 2 Appeal to the Independent Review Organization **within 24 hours** of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The

complaint process is different from the appeals process. 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.

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

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say **no** to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an administrative law judge or attorney adjudicator.
- 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. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

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

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

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

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

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

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

- This is the last step of the appeals process.

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

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

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

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

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

- This is the last step of the appeals process.

MAKING COMPLAINTS

Section 10 — How to make a complaint about quality of care, waiting times, customer service, or other concerns

? If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 in this chapter.

Section 10.1 – What kinds of problems are handled by the complaint process?

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

If you have any of these kinds of problems, you can "make a complaint":

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

- Do you think written information we have given you is hard to understand?

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

The process of asking for a coverage decision and making appeals is explained in Sections 4 through 9 of this chapter. If you are asking for a coverage decision or making an appeal, you use that process, not the complaint process.

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

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

Section 10.2 – The formal name for "making a complaint" is "filing a grievance"

Legal Terms	What this section calls a **"complaint"** is also called a **"grievance."** Another term for **"making a complaint"** is **"filing a grievance."** Another way to say "using the process for complaints" is **"using the process for filing a grievance."**

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. Please call us at **1-800-443-0815** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.
- **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**.

- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal,"** we will automatically give you a "fast complaint." If you have a "fast complaint," it means we will give you an answer **within 24 hours**.

Note: You have additional dispute resolution rights and a different appeal process through the FEHB Program. For a complete statement of your benefits and rights under the FEHB Program, please read your FEHB brochure (RI 73-889). All FEHB benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB brochure.

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Legal Terms	What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

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

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 10.4 – You can also make complaints about quality of care to the Quality Improvement Organization

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

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

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

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.** Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please 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

Section 1.1 – This chapter focuses on ending your Senior Advantage membership

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.**
  - You can disenroll from Medicare Part B or from Senior Advantage for Federal Members at any time and keep only your original FEHB coverage.
- There are also limited situations where you do not choose to leave, but we are required to end your Senior Advantage membership. Section 5 in this chapter tells you about situations when we must end your Senior Advantage membership.

Section 2 — When can you end your Senior Advantage membership in our plan?

Section 2.1 – You can end your Senior Advantage membership at any time

You may terminate (disenroll from) your Senior Advantage membership at any time.

If you request disenrollment, your disenrollment effective date will be the first day of the month following our receipt of your disenrollment request.

When your Senior Advantage coverage ends, you may continue your FEHB membership if you still meet the requirements for FEHB coverage. Your benefits and copayments are not the same and are described in the FEHB brochure (RI 73-889).

Other Medicare health plans

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

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

Original Medicare

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

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

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 5, for more information about the late enrollment penalty.

Section 2.2 —– Where can you get more information about when you can end your Senior Advantage membership?

If you have any questions or would like more information about when you can end your Senior Advantage membership:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the **Medicare & You** 2022 handbook.
  - Everyone with Medicare receives a copy of the **Medicare & You** 2022 handbook each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (**www.medicare.gov**). Or you can order a printed copy by calling Medicare at the number below.
- You can contact 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 — How do you end your Senior Advantage membership?

Section 3.1 – There are several ways to end your Senior Advantage membership

You may request disenrollment by:

- Calling toll free **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
- Sending written notice to the following address:

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

Section 4 — Until your Senior Advantage membership ends, you must keep getting your medical services and drugs through our plan

Section 4.1 – Until your Senior Advantage membership ends, you are still a member of our plan

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 in this chapter for information about when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy, including through our mail-order pharmacy services.
- If you are hospitalized on the day that your membership ends, your hospital stay will usually 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 Senior Advantage membership in our plan in certain situations

Section 5.1 – When must we end your Senior Advantage membership?

We must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - ♦ If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. Phone numbers for Member Services are printed on the back cover of this booklet.
  - ♦ If you have been a member of our plan continuously since before January 1999, and you were living outside of our service area before January 1999, you are still eligible as long as you have not moved since before January 1999. However, if you move and your move is to another location that is outside of our service area, you will be disenrolled from our plan.
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about 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:

- You can call Member Services for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2 – We cannot ask you to leave our plan for any reason related to your health

We are not allowed to ask you to leave our plan for any reason related to your health.

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, you should call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You may call 24 hours a day, 7 days a week.

Section 5.3 – You have the right to make a complaint if we end your Senior Advantage membership

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 make a complaint about our decision to end your membership. You can look in Chapter 9, Section 10, for information about how to make a complaint.

Section 5.4 – What happens if you are no longer eligible for FEHB 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 FEHB 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 **Evidence of Coverage** 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 our Member Service Contact Center.

Chapter 11 — Legal notices

Section 1 — Notice about governing law

Many laws apply to this **Evidence of Coverage** and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this 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.

Section 2 — Notice about nondiscrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, 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.

If you have a disability and need help with access to care, please call Member Services (phone numbers are printed on the back cover of this booklet). 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 — 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 6 — 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 7 — 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 8 — Coordination of benefits

As described in Chapter 1 (Section 10) "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 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 16 in this chapter, and for primary payments in workers' compensation cases, see Section 18 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 9 — 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 10 — 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 11 — 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 12 — 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 13 — 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 14 — 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 booklet) and Social Security at **1-800-772-1213** (TTY **1-800-325-0778**) as soon as possible to report your address change.

Section 15 — 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 16 — Third party liability

As stated in Chapter 1, Section 10, 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
Kaiser Permanente – Northern California Region
Subrogation Mailbox
P.O. Box 36380
Louisville, KY 40233
Fax: **1-502-214-1137**

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

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

Section 17 — 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 18 — Workers' compensation or employer's liability benefits

As stated in Chapter 1, Section 10, workers' compensation usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue primary payments under workers' compensation or employer's liability law. You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered services from the following sources:

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

Section 19 — Surrogacy

In situations where a member receives monetary compensation to act as a surrogate, our plan will seek reimbursement of all Plan Charges for covered services the member receives that are associated with conception, pregnancy and/or delivery of the child. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Section 20 — Binding arbitration

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

Scope of arbitration

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

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

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

- Claims within the jurisdiction of the Small Claims Court.
- Claims subject to a Medicare appeal procedure as applicable to Kaiser Permanente Senior Advantage Members (see Chapter 9 for Medicare appeal information).
- Claims that cannot be subject to binding arbitration under governing law.

As referred to in this "Binding Arbitration" provision, "member Parties" include:

- A member.
- A member's heir, relative, or personal representative.
- Any person claiming that a duty to him or her arises from a member's relationship to one or more Kaiser Permanente Parties.
- "Kaiser Permanente Parties" include:
- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals.
- KP Cal, LLC.
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group.
- The Permanente Federation, LLC.
- The Permanente Company, LLC.
- Any Southern California Permanente Medical Group or The Permanente Medical Group physician.
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more member Parties.
- Any employee or agent of any of the foregoing.

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

Rules of procedure

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

Initiating arbitration

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

Serving demand for arbitration

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

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

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

Filing fee

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

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

Number of arbitrators

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

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

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

Payment of arbitrators' fees and expenses

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

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

Costs

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

General provisions

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

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

Arbitrations shall be governed by this "Binding Arbitration" provision, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this section. In accord with the rule that applies under Sections 3 and 4 of

the Federal Arbitration Act, the right to arbitration under this section shall not be denied, stayed, or otherwise impeded because a dispute between a member Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with a third party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Chapter 12 — Definitions of important words

Allowance – A specified credit amount that you can use toward the cost of an item. If the cost of the item(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. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

ASH Participating Provider – A chiropractor who is licensed to provide chiropractic services in California and who has a contract with ASH plans to provide medically necessary chiropractic services to you. A list of participating providers is available on the ASH plans website at **www.ashlink.com/ash/kaisercamedicare** or from the ASH plans customer service department toll free at **1-800-678-9133** (TTY users call **711**). The list of participating providers is subject to change at any time, without notice. If you have questions, please call the ASH plans customer service department.

ASH Plans – American Specialty Health Plans of California, Inc., a California corporation.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than 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 haven't 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 **$7,050** in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Chiropractic Services – Chiropractic services include spinal and extremity manipulation and adjunctive therapies such as ultrasound, therapeutic exercise, or electrical muscle stimulation, when provided during the same course of treatment and in conjunction with chiropractic manipulative services, and other services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic supports and appliances) for the treatment of your musculoskeletal and related disorder.

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%) of Plan Charges.

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Comprehensive Formulary (Formulary or "Drug List") – A list of prescription drugs covered by our plan. The drugs on this list are selected by us with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services, including 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 10) and Chapter 11 (Section 8) for more information.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

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. 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. **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 four cost-sharing tiers.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you 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 booklet. Chapter 9 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The general 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 is personal care that can be provided by people who don't have professional skills or training, such as 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. This means you pay $1 for each day's supply when you fill your prescription.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

DeltaCare USA Dentist – A dentist who provides services in general dentistry, and has agreed to provide covered DeltaCare USA services to members.

DeltaCare USA Specialist – A dentist who provides specialist services, and has agreed to provide covered DeltaCare USA services to members.

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech-generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, 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.

Emergency Care – Covered services that are (1) rendered by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Emergency Chiropractic Services – Covered chiropractic services provided for the treatment of a musculoskeletal and related disorder which manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate chiropractic services to result in serious jeopardy to your health or body functions or organs.

Emergency Dental Care – For members who are enrolled in DeltaCare USA, care provided by a dentist to treat a dental condition that manifests as a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected by the member to result in either: (1) placing the member's dental health in serious jeopardy, or (2) serious impairment to dental functions. "Reasonably" in this case means that a member exercises prudent judgment in determining that a dental emergency exists and contacts his or her DeltaCare USA dentist to obtain emergency care. If the dentist is not available, members must call Delta Dental Customer Service before getting care from another dentist if reasonably possible considering the nature of the situation at **1-800-422-4234**, Monday through Friday, 5 a.m. to 6 p.m. (TTY users should call **1-800-735-2929**). See Chapter 4 for more information about DeltaCare USA coverage.

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.

Enrollee – An eligible employee ("Primary Enrollee") enrolled to receive DeltaCare USA dental benefits.

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 your plan sponsor's formulary (a formulary exception).

Excluded Drug – A drug that is not a "covered Part D drug," as defined under 42 U.S.C. Section 1395w-102(e).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Family – A subscriber and all of his or her dependents.

FEHB – The Federal Employees Health Benefits Program.

Formulary – A list of Medicare Part D drugs covered by our plan.

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 us, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A home health aide provides services that don't 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 aides do not have a nursing license or provide therapy.

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Medical Benefits Chart in Chapter 4. We cover home health care in accord with Medicare guidelines. Home health care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you 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 member who has six months or less to live has the right to elect hospice. 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. The hospice will provide special treatment for your state.

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 **$7,050**.

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. For example, 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, Inc., Northern California Region, 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 towards your FEHB contribution and your Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.2, for information about your 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. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6, for information about how to contact Medicaid in your state.

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 The Permanente Medical Group, Inc., 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. See Chapter 5, Section 3, for more information about a medically accepted indication.

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). People with Medicare can get their Medicare health coverage through Original Medicare, a PACE plan, or a Medicare Advantage Plan.

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 an HMO, a PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and are not paid for under Original Medicare. 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.** Everyone who has Medicare Part A and Part B is eligible to join any Medicare Advantage health plan that is offered in their area.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/ Pilot Programs, and Programs of All-Inclusive Care for the Elderly (PACE).

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. See Chapter 2 for information about how to contact Member Services.

Musculoskeletal and Related Disorders – Conditions with associated signs and symptoms related to the nervous, muscular, or skeletal systems. Musculoskeletal and related disorders are conditions typically categorized as structural, degenerative, or inflammatory disorders, or biomechanical dysfunction of the joints of the body or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs, and synovial structures), and related neurological manifestations or conditions.

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. 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 we use 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. We call them "network providers" when they 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. We pay network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision 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 booklet. Chapter 9 explains how to ask us for a coverage decision.

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 doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this **Evidence of Coverage**, 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 with which we have not arranged 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 or are not

under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

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, while getting the high-quality care they need. 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. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

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. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty.

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) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1, for information about primary care providers.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4 and described in Chapter 3, Section 2.3. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, 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 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. See Chapter 2, Section 4, for information about how to contact the QIO for your state.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. 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 may disenroll you if you permanently move out of our 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 skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Health Care Need – A physical or mental impairment, limitation or condition that substantially interferes with an Enrollee's ability to obtain DeltaCare USA HMO Program benefits. Examples of such a Special Health Care Need are 1) the Enrollee's inability to obtain access to the assigned DeltaCare USA dentist's facility because of a physical disability and 2) the Enrollee's inability to comply with the DeltaCare USA dentist's instructions during examination or treatment because of physical disability or mental incapacity.

Specialty-Tier Drugs – Very high-cost drugs approved by the FDA that are on our formulary.

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

Subscriber – A member who is eligible for membership on his or her own behalf and not by virtue of dependent status.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Treatment Plan – The course of treatment for your musculoskeletal and related disorder, which may include laboratory tests, X-rays, chiropractic supports and appliances, and a specific number of visits for chiropractic manipulations (adjustments) and adjunctive therapies that are medically necessary chiropractic services for you.

Urgent Chiropractic Services – Chiropractic services that meet all of the following requirements:

- They are necessary to prevent serious deterioration of your health resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy.
- They cannot be delayed until you return to the service area.

Urgently Needed Services – Urgently needed services are provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

KAISER PERMANENTE®

Kaiser Permanente Senior Advantage Member Services

METHOD	Member Services — contact information
CALL	**1-800-443-0815** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services 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	Member Services office located at a network facility (refer to our **Provider Directory** for locations).
WEBSITE	**kp.org**

State Health Insurance Assistance Program

A State Health Insurance Assistance Program (SHIP) is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. Please see Chapter 2, Section 3, for SHIP contact information.

Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

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

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

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

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Multi-language Interpreter Services

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

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

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

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

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

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-800-443-0815 (TTY: **711**)번으로 전화해 주십시오.

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

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

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

Punjabi
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।

1-800-443-0815 (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

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

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

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

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

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

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم - **1-800-443-0815** (رقم هاتف الصم والبكم: -**711**).