KAISER PERMANENTE®

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

April 27, 2026

Cypress Williams
Reed College
3203 Se Woodstock Blvd
Portland, OR 97202

Group number: 1780-019

Dear Cypress,

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

Enclosed is the Senior Advantage with Part D Plan *Group Agreement* effective 01/01/2026 through 12/31/2026 for Reed College. The *Group Agreement* includes group contract provisions, such as monthly Premium amounts, and incorporates the *Evidence of Coverage (EOC),* which is the member portion of the contract. The *EOC* explains benefits and cost share amounts, limitations, exclusions, and other information to help the member understand their plan.

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

We know you have a choice of health plans, and we appreciate your business. If you have any questions about this *Group Agreement* or your health plan, please contact your account management team.

Sincerely,

Kaiser Permanente Sales & Account Management Team
Enclosures

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

KAISER PERMANENTE®

2026 *Group Agreement* and *Evidence of Coverage* Summary of Changes and Clarifications for Oregon Large Employer Groups

This is a summary of changes and clarifications that we made to your *Group Agreement* for the 2026 plan year. The *Group Agreement* includes the *Evidence of Coverage* (*EOC*), *Benefit Summary*, and any applicable notices, riders, and endorsement documents. This summary does not include minor changes and clarifications we are making to improve the readability and accuracy of the *Group Agreement*, or changes that may occur throughout the remainder of the plan year as a result of federal or state mandates.

Other plan-specific or product-specific benefit changes, including changes to deductible, copayment, or coinsurance amounts, may apply to your plan. Please refer to the 2026 renewal proposal and/or confirmation for your group and the 2026 Oregon and Washington Plan Changes document for information about these types of changes.

This Summary of Changes and Clarifications supplements the information contained in your *Group Agreement*. In the event of conflict between this summary and the *Group Agreement*, the *Group Agreement* shall control. Unless another date is listed, the changes described in this summary are effective when your *Group Agreement* renews in 2026. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

Changes and Clarifications that Apply to Medical Plans

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

Benefit Changes

- **Allergy Serum.** We added an "Allergy serum" row under the "Outpatient Services" section of the *Benefit Summary* to indicate that allergy serums are now subject to Cost Sharing.
- **Breast Imaging Services.** We revised the "Preventive Care Services" and "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" sections of the *EOC* to indicate that breast imaging conducted prior to a breast cancer diagnosis is considered preventive and is not subject to the deductible in High Deductible plans; breast imaging conducted following a breast cancer diagnosis is considered diagnostic and supplemental, and is therefore subject to the deductible in High Deductible plans.
- **Birthing Centers.** The "Maternity and Newborn Care" sections of the *EOC* and *Benefit Summary* were updated as follows:
  - The exclusion for birthing centers was removed from the *EOC*.
  - A new bullet titled "Birthing center Services" was added to the *EOC*.
  - A corresponding row for "Birthing center Services" was added to the *Benefit Summary*.
- **Doula Coverage.** In accordance with Oregon Senate Bill 692, we revised the "Maternity and Newborn Care" sections of the *EOC* and *Benefit Summary* to reflect coverage for both inpatient and outpatient doula Services.
- **Prosthetic and Orthotic Devices for Physical Activity.** In accordance with Oregon Senate Bill 699, we updated the "External Prosthetic Devices and Orthotic Devices" section of the *EOC* to clarify we

now cover devices that are Medically Necessary for physical activities, including but not limited to running, biking, swimming, and strength training.

Benefit Clarifications

- **Hearing Aid Age Limits.** We updated the age limitation language in the "Hearing Aids and Other Hearing Devices" section of the *EOC* and *Benefit Summary* to clearly indicate those Services are only covered for Members under age 26.
- **Habilitative and Rehabilitative Therapy Services Prior Authorization.** We revised the bullet for outpatient habilitative and rehabilitative therapy services in the "Services Subject to Prior Authorization Review" section of the Added Choice®, PPO Plus, and Dual Choice PPO™ *EOC*s to clarify that these services do not require prior authorization when rendered by a covered provider.
- **HIV Prevention Drugs.** In accordance with Oregon House Bill 2292, we added a bullet in the "Preventive Services" section of the *EOC* clarifying that we also cover Services necessary for the continuation of HIV prevention drugs as preventive.
- **Limited Dental Services Exclusions.** We removed the redundant "except as" clauses from several of the bullets in the "Limited Dental Services Exclusions" section of the *EOC,* as those exceptions are already outlined in the introductory sentence.

Other Changes or Clarifications

- **Abortion Services Terminology.** We changed the term "interrupted pregnancy" to "abortion Services" throughout the *EOC* and *Benefit Summary*.
- **Active & Fit Vendor Change.** We updated the "Healthy Resources" section of the *EOC* to reflect our new Optum vendor programs. These include the One Pass™ Select Affinity and affinity musculoskeletal programs, which have replaced The ChooseHealthy programs. To learn more about these programs, visit **healthy.kp.org/oregon-washington/health-wellness/fitness-offerings**.
- ***EOC* Cover URL.** We updated the URL on the Added Choice®, Kaiser Permanente Plus™, PPO Plus, and Dual Choice PPO™ *EOC* cover page from **kp.org** to **kp.org/choiceproducts/nw** for a more direct link to Choice Product specific content.
- **Gender Neutral Language.** We made minor updates throughout the *EOC* to remove gendered language in relation to surrogacy arrangements.
- **Group Agreement.** The "Amendment due to Tax or Other Charges" section was removed from the *Group Agreement* as we do not increase rates during the plan year.
- **Health Record Number Terminology Change.** We changed the term "health record number" to "medical record number" throughout the *EOC* for regional consistency.
- **Kaiser Permanente Rewards Program.** We added a bullet to the "Healthy Resources" section of the *EOC* with information on the new Kaiser Permanente rewards program.
- **Nondiscrimination Notice Changes.** Changes were made to the "Nondiscrimination Statement and Notice of Language Assistance" section of the *EOC* to incorporate the U.S. Department of Health and Human Services final rule, interpreting Section 1557 of the Affordable Care Act (ACA).
- **Post-Service Claims URL Update.** We updated the URL in the Kaiser Permanente Plus™ *EOC,* "Post-service Claims - Services Already Received" section, from **kp.org** to **kp.org/choiceproducts/nw** for a more direct link to claim reimbursement forms.
- **Premium Payment Address Change.** In the "Notices" section of the *Group Agreement*, we updated the physical address where groups can send their premium payments to align with administrative changes.

- **Primary Care Provider Selection Process.** We made minor updates to the "Your Primary Care Provider" section of the *EOC* to clarify that if a Member does not select a Primary Care Provider (PCP) within 90 days of enrollment, one will be assigned to them.
- **Prior Authorization Requirements.** In accordance with Oregon House Bill 3134, we updated the "Prior Authorization Review Requirements" section of the *EOC* to clarify that prior authorization is not required when a provider determines, during a previously authorized surgery, that an additional procedure is Medically Necessary.
- **Subscriber Live and Work Eligibility.** In the Traditional, Deductible, High-Deductible, and Kaiser Permanente Plus™ *EOC*s, we revised the "Subscribers" section to update the live and work eligibility criteria language.
- **Surrogacy Arrangement Contact Change.** We updated the contact listed in the "Surrogacy Arrangements - Traditional and Gestational Carriers" section of the *EOC* to "The Phia Group."
- **The CHP Group Name Change.** The CHP Group, which is the provider group we contract with to provide alternative care Services, changed its name to Heraya Health. We made edits throughout the Traditional, Deductible, High Deductible, Kaiser Permanente Plus™, and Added Choice® *EOC*s to reflect the new name and URL.

Changes and Clarifications that Apply to Medical Benefit Riders

Benefit Changes

- **Outpatient Prescription Drug Rider Limitation.** We updated the prescription refills bullet in the "Outpatient Prescription Drug Rider Limitations" section of the *Outpatient Prescription Drug Rider* to state that members must use at least 80 percent of the quantity of a prescription before it can be refilled.
- **The CHP Group Name Change.** The CHP Group, which is the provider group we contract with to provide alternative care Services, changed its name to Heraya Health. We made edits throughout the *Alternative Care Services Rider* to reflect the new name and URL.

Benefit Clarifications

- **Hearing Aid Rider Age Limits.** We updated the age limitation language in the *Hearing Aid Rider* to indicate that Services covered under the rider are only for Members 26 years of age and older.
- **Weight Management Drugs.** For groups that cover weight management drugs under their *Outpatient Prescription Drug Rider*, we added a "Weight management drugs" row to the rider benefit summary section to more clearly display the Cost Share structure for weight management drugs when covered by the group.

Changes and Clarifications that Apply to Dental Plans

Benefit Changes

- **Dental Emergency Benefit.** In our Traditional plans, the Dental Emergency benefit for Non-Participating Providers outside of the Service Area was changed from all charges over $100 to the Cost Share that normally applies for non-emergency dental care Services, plus amounts that exceed Usual and Customary charges for qualifying claims.
- **Minor Restorative Services.** We added synthetic as a material option to the "Restorations" row in the *Benefit Summary*.

- **Nitrous Oxide.** We changed the nitrous oxide Cost Share listed on the *Benefit Summary* for "Children age 12 years and younger" from $0 to $25, making the Cost Share the same for all ages.
- **Partial Dentures Frequency.** We updated the limitations section of the Essential Saver Exclusive Provider Organization (EPO) and Dental Choice Preferred Provider Organization (PPO) *EOC*s to clarify that all partial dentures have a frequency of once every three years, regardless of material type.
- **Routine Filling Limitation Removal.** The limitation restricting composite (tooth-colored) fillings to anterior and bicuspid teeth has been removed from the *EOC*.

Other Changes or Clarifications

- **Group Agreement.** The "Amendment due to Tax or Other Charges" section was removed from the *Group Agreement* as we do not increase rates during the plan year.
- **Health Record Number Terminology Change.** We changed the term "health record number" to "medical record number" throughout the *EOC* for regional consistency.
- **Nondiscrimination Notice Changes.** Changes were made to the "Nondiscrimination Statement and Notice of Language Assistance" section of the *EOC* to incorporate the U.S. Department of Health and Human Services final rule, interpreting Section 1557 of the Affordable Care Act (ACA).
- **Premium Payment Address Change.** In the "Notices" section of the *Group Agreement*, we updated the physical address where groups can send their Premium payments, to align with administrative changes.
- **Prior Authorization Changes.** We updated the "Prior Authorization" section in the Essential Saver Exclusive Provider Organization (EPO) and Dental Choice Preferred Provider Organization (PPO) *EOC*s to reflect that we are removing the $500 criteria for Services that require Prior Authorization and instead have posted a list of Services that require Prior Authorization online at **kp.org/dental/nw/epo** and **kp.org/dental/nw/ppo.**
- **Subscriber Live and Work Eligibility.** In the Traditional Dental *EOC*s, we revised the "Subscribers" section to update the live and work eligibility criteria language.

Changes and Clarifications that Apply to Senior Advantage Plans

Benefit Changes

- **Part D Out-of-Pocket Costs.** For groups with Part D coverage, we updated Chapter 6, Sections 1.2, 5.5, and 6, of the *EOC* to show that the amount of out-of-pocket costs that a member must pay for Part D prescription drugs before moving from the Initial Coverage Stage to the Catastrophic Coverage Stage changed from $2,000 to $2,100.

Benefit Clarifications

- **Colorectal Cancer Screening.** In the *Medical Benefits Chart* of the *EOC*, we updated this row to show that coverage is provided without cost sharing for computed tomography colonography under certain circumstances.
- **Formulary Exception for Brand-Name Drugs.** For groups with Part D coverage, we updated Chapter 9, Section 6.2, of the *EOC* to explain that if you request, and we agree to cover, a Part D brand-name drug not on our Drug List, you will need to pay the cost-sharing amount that applies to Tier 5 for specialty drugs instead of Tier 4 for non-preferred drugs.
- **Medicare Prescription Payment Plan.** For groups with Part D coverage, we updated Chapter 2, Section 7, of the *EOC* to clarify that if you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.

- **Nursing Hotline.** In the *Medical Benefits Chart* of the *EOC*, we added a row to clarify that telephone advice from registered nurses is available without cost sharing.
- **Pre-Exposure Prophylaxis (PrEP) for HIV Prevention.** In the *Medical Benefits Chart* of the *EOC*, we added a row to clarify that if you don't have HIV and your doctor determines you are at increased risk for HIV, pre-exposure prophylaxis (PrEP) medication and related services are available without cost sharing.
- **Screening for Hepatitis C Virus Infection.** In the *Medical Benefits Chart* of the *EOC*, we added a row to clarify that screenings for Hepatitis C virus infection are covered under certain conditions without cost sharing.

Other Changes or Clarifications

- **The CHP Group Name Change.** The CHP Group, which is the provider group we contract with to provide alternative care services, changed its name to Heraya Health. We updated the provider group's name and URL in the *Acupuncture Services Rider, Chiropractic Services Rider, Massage Therapy Services Rider,* and *Naturopathic Medicine Rider*.

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation

Portland, Oregon

Large Group Senior Advantage Plan with Part D Group Agreement

Group Name: Reed College

Group Number: 1780 – 019

Term of *Agreement*

01/01/2026, through 12/31/2026

Anniversary date

January 1



Authorized representative

TABLE OF CONTENTS

Introduction 1

Premium 1

Monthly Payments 1

Monthly Premium Amounts 1

Term of *Agreement,* Acceptance of *Agreement,* and Renewal 2

Term of *Agreement* 2

Acceptance of *Agreement* 2

Renewal 2

Amendment of *Agreement* 2

Amendments Effective on Anniversary Date 2

Amendment Due to Medicare Changes 2

Other Amendments 2

Termination of *Agreement* 3

Termination on Notice 3

Termination for Nonpayment 3

Termination for Fraud 3

Termination for Violation of Contribution or Participation Requirements 4

Termination for Discontinuance of a Product or all Products within a Market 4

Contribution and Participation Requirements 4

Subscriber Contributions for Medicare Part C and Part D Coverage 5

Medicare Part C Coverage 5

Medicare Part D Coverage 5

Miscellaneous Provisions 6

Administration of *Agreement* 6

Assignment 6

Attorney Fees and Costs 7

Governing Law 7

No Waiver....7
Notices....7
Reporting Membership Changes and Retroactivity....8
Involuntary Kaiser Permanente Senior Advantage Membership Terminations....8
Voluntary Kaiser Permanente Senior Advantage Membership Terminations....8
Social Security and Tax Identification Numbers....8

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST

A Nonprofit Corporation

Group Agreement

INTRODUCTION

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

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

PREMIUM

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

Monthly Payments

Group will pay to Health Plan, for each Subscriber and his or her Dependents, the Premium amount(s) specified for each month on or before the date on the monthly invoice or, if Group is self-pay, then the date to which Health Plan and Group agree in writing, but in no event later than the last day of the month preceding the month of coverage (the "Premium Due Date"). If Group fails to make payments on or before the Premium Due Date, then upon renewal and at Health Plan's option (and in lieu of any other remedy), the new Premium may include an additional charge.

When this *Agreement* terminates, if Group does not have another agreement with Health Plan, then the due date for all Premium amounts will be the earlier of: (1) the last Premium Due Date, or (2) the termination date of this *Agreement*.

Monthly Premium Amounts

Medicare as Primary Payer

For each Member eligible for benefits under Part A, enrolled in Part B, and eligible for Part D of Medicare who has enrolled in Kaiser Permanente Senior Advantage with Part D, Group will pay Health Plan the following Premium: $279.60

Medicare as Secondary Payer

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

For each Member eligible for benefits under Part A, enrolled in Part B, and eligible for Part D of Medicare who has enrolled in Kaiser Permanente Senior Advantage with Part D, Group will pay Health Plan the following Premium: $829.46

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

Term of *Agreement*

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

Acceptance of *Agreement*

Group will be deemed as having accepted this *Agreement* and any amendments issued during the term of this *Agreement,* if Group pays Health Plan any amount toward Premium.

Group may not change this *Agreement* by adding or deleting words, and any such addition or deletion is void. If Group wishes to change anything in this *Agreement,* Group must contact its Health Plan account manager. Health Plan might not respond to any changes or comments that Group may submit. Group may not construe Health Plan's lack of response to any submitted changes or comments to imply acceptance. Health Plan will issue a new agreement or amendment if Health Plan and Group agree on any changes.

Renewal

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

AMENDMENT OF *AGREEMENT*

Amendments Effective on Anniversary Date

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

Amendment Due to Medicare Changes

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

Other Amendments

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

TERMINATION OF *AGREEMENT*

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

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

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

Termination on Notice

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

Termination for Nonpayment

When Group fails to pay Premium on or before the Premium Due Date, Group shall have a period of at least 31 days to pay all Premiums owed ("Grace Period"). The Grace Period shall begin the day after the Premium Due Date. If Group fails to pay all Premiums owed (including those owed for the Grace Period) on or before the last day of the Grace Period, then Health Plan may, at its option and in lieu of any other remedy, terminate this *Agreement* without further extension or consideration.

Health Plan will notify Group of the past-due amount and the effective date of termination. Such notice shall be sent at least 10 days prior to the effective date of termination. Group shall continue to be liable for all Premiums due through the date of termination.

This *Agreement* will remain in full force and effect throughout the Grace Period and Group will remain responsible for payment of Premiums. If Health Plan receives full payment of Premiums on or before the last day of the Grace Period, this *Agreement* will remain in effect according to its terms and conditions.

If Premiums are paid after the Grace Period ends, Health Plan may charge interest on the overdue Premiums. Interest shall not accrue during the Grace Period, and the (simple) interest rate shall be 6 percent per year or the maximum amount permitted by applicable law, whichever is less.

Termination for Fraud

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

Termination for Violation of Contribution or Participation Requirements

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

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

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

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

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

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

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

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

CONTRIBUTION AND PARTICIPATION REQUIREMENTS

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

Group must:

- Meet all underwriting requirements set forth in Health Plan's Rate Assumptions and Requirements document.

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

SUBSCRIBER CONTRIBUTIONS FOR MEDICARE PART C AND PART D COVERAGE

Medicare Part C Coverage

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

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

Medicare Part D Coverage

This "Subscriber Contributions for Medicare Part D Coverage" section applies only to Group's Kaiser Permanente Senior Advantage coverage that includes Medicare Part D prescription drug coverage. Group's Senior Advantage monthly Premium includes the Medicare Part D premium. Group may determine how much it will require subscribers to contribute toward the Medicare Part D premium for each Senior Advantage Member in the Subscriber's Family, subject to the following restrictions:

- If Group requires different contribution amounts for different classes of Senior Advantage Members for the Medicare Part D premium, then Group agrees to the following:

- Any such differences in classes of Members are reasonable and based on objective business criteria, such as years of service, business location, and job category, and are not based on eligibility for the Medicare Part D Low Income Subsidy (the subsidies described in 42 C.F.R. Section 423 Subpart P, which are offered by the Medicare program to certain low-income Medicare beneficiaries enrolled in Medicare Part D, and which reduce the Medicare beneficiaries' Medicare Part D premiums and/or Medicare Part D cost-sharing amounts).
- Group will not require different subscriber contributions toward the Medicare Part D premium for Members within the same class.

- Group will not require subscribers to pay a contribution for prescription drug coverage for a Senior Advantage Member that exceeds the Premium for prescription drug coverage (including the Medicare Part D premium). The Group will pass through direct subsidy payments received from CMS to reduce the amount the Member contributes toward the Medicare Part D premium.

- Health Plan will credit Group with any Low Income Subsidy amounts that Health Plan receives from CMS for Group's Members and Health Plan will identify those Members for Group as required by CMS. For those Members, Group will first credit the Low Income Subsidy amount toward the Subscriber's contribution for that Member's Senior Advantage Premium for the same month, and will then apply any remaining portion of the Member's Low Income Subsidy toward the portion of the Senior Advantage Premium that Group pays on behalf of that Member for that month. If Group is unable to reduce the Subscriber's contribution before the Subscriber makes the contribution, Group shall, consistent with CMS guidance, refund the Low Income Subsidy amount to the Subscriber (up to the amount of the Subscriber Premium contribution for the Member for that month) within 45 days after the date Health Plan receives the Low Income Subsidy amount from CMS. Health Plan reserves the right to periodically require Group to certify that Group is either reducing Subscribers' monthly Premium contributions or refunding the Low Income Subsidy amounts to Subscribers in accord with CMS guidance.

- For any Members who are eligible for the Low Income Subsidy, if the amount of that Low Income Subsidy is less than the Member's contribution for the Medicare Part D premium, then Group should inform the Member of the financial consequences of the Member's enrolling in the Member's current coverage, as compared to enrolling in another Part D plan with a Premium equal to or less than the Low Income Subsidy amount.

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

MISCELLANEOUS PROVISIONS

Administration of *Agreement*

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

Assignment

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

Attorney Fees and Costs

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

Governing Law

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

No Waiver

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

Notices

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

Notices from Health Plan to Group will be sent to:

Group Contact	Cypress Williams
Group Name	Reed College
Group Address	3203 Se Woodstock Blvd
Group Address	
Group Address	Portland, OR 97202

Producer Contact	Rico Bocala
Producer Name	Usi Midwest Inc.
Producer Address	312 Elm St.
Producer Address	
Producer Address	Cincinnati, OH 45202-0

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

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

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

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

Kaiser Foundation Health Plan of the Northwest
PO Box 741562
Los Angeles, CA 90074

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

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

Reporting Membership Changes and Retroactivity

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

Involuntary Kaiser Permanente Senior Advantage Membership Terminations

Group must give Health Plan's San Diego Service Center 30 days prior written notice of Senior Advantage involuntary membership terminations. An involuntary Kaiser Permanente Senior Advantage membership termination is a termination that is not in response to a disenrollment notice issued by CMS to Health Plan or received by Health Plan directly from a Member (these events are usually in response to a Member's request for disenrollment to CMS because the Member has enrolled in another Medicare health plan or wants Original Medicare coverage or has lost Medicare eligibility). The membership termination date is the first of the month following 30 days after the date when Health Plan's San Diego Service Center receives a Senior Advantage membership termination notice unless Group specifies a later termination date. For example, if Health Plan's San Diego Service Center receives a termination notice on March 5 for a Senior Advantage Member, the earliest termination date is May 1 and Group is required to pay applicable Premiums for the months of March and April.

Voluntary Kaiser Permanente Senior Advantage Membership Terminations

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

Social Security and Tax Identification Numbers

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

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

GUIDE TO YOUR BENEFITS AND SERVICES

kp.org

Medical Benefits Chart: Senior Advantage with Part D

Reed College
1780 - 019

For group benefits effective 01/01/2026, through 12/31/2026

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

Covered Service	What you pay
Maximum out-of-pocket amount	**$2,000**
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 (physician-referred)† Covered services include: • Up to 12 visits in 90 days are covered under the following circumstances: o For the purpose of this benefit, chronic low back pain is defined as: ▪ Lasting 12 weeks or longer; ▪ nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); ▪ not associated with surgery; and ▪ not associated with pregnancy. An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements.	**$20 per visit**

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

Covered Service	What you pay
Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by regulations at 42 CFR §§ 410.26 and 410.27.	
Alternative care therapies (self-referred)	
• Acupuncture services (up to 12 visits per calendar year)	**$25 per visit** (If covered, see the Acupuncture Services Rider in the **EOC** for additional information.)
• Chiropractic services (up to 20 visits per calendar year)	**$25 per visit** (If covered, see the Chiropractic Services Rider in the **EOC** for additional information.)
• Massage therapy (up to 12 visits per calendar year)	**$25 per visit** (If covered, see the Massage Therapy Rider in the **EOC** for additional information.)
• Naturopathic medicine	**$35 per visit** (If covered, see the Naturopathic Medicine Rider in the **EOC** for additional information.)

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

Covered Service	What you pay
Ambulance services Covered ambulance services, whether for an emergency or †non-emergency situation, include fixed wing, rotary wing, and ground ambulance services to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. We also cover the services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) if you reasonably believe that you have an emergency medical condition and you reasonably believe that your condition requires the clinical support of ambulance transport services.	**$150** per one-way trip
Annual routine physical exam Routine physical exams are covered if the exam is medically appropriate preventive care in accord with generally accepted professional standards of practice.	There is no coinsurance, copayment, or deductible for this preventive care.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following	There is no coinsurance, copayment, or deductible for Medicare covered bone mass measurement.

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

Covered Service	What you pay
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.	
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services† Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**$20** per visit
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.

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

Covered Service	What you pay
• If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months.	
Chiropractic services (physician-referred)† Covered services include: • We cover only manual manipulation of the spine to correct subluxation. o These Medicare-covered services are provided by a network chiropractor. For the list of network chiropractors, please refer to the **Provider Directory**.	**$20 per visit**
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	Cost sharing for this service will vary depending on individual services provided under the course of treatment. **Primary care office visits** • **$30** per visit **Specialist office visits†** • **$35** per visit
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high-risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening	There is no coinsurance, copayment, or deductible for a Medicare covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and you pay **$0**.

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

Covered Service	What you pay
computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
• Procedures performed during a screening colonoscopy (for example, removal of polyps). • Colonoscopies following a positive gFOBT or FIT test or a flexible sigmoidoscopy screening. **Note:** All other colonoscopies are subject to the applicable cost sharing listed elsewhere in this chart.	**$0**
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.

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

Covered Service	What you pay
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.
Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • †Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.	**$0**
• †For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.	**20% Coinsurance**
Diabetes self-management training is covered under certain conditions.	**$0**
Durable medical equipment (DME) and related supplies† (For a definition of durable medical equipment, go to Chapter 12 and Chapter 3.) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen	You pay: • **$0** for ultraviolet light therapy equipment for psoriasis treatment, CADD pumps, bone/spine stimulators, ventilators and enteral pumps/supplies • **20% Coinsurance** for all other DME

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

Covered Service	What you pay
equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at **kp.org/directory**. We also cover the following DME not covered by Medicare when medically necessary: • Bed accessories when bed extension is required. • Iontophoresis device to treat hyperhidrosis when antiperspirants are contraindicated and the hyperhidrosis has created medical complications or is preventing daily living activities. • Resuscitation bag if tracheostomy patient has significant secretion management problems, needing lavage and suction technique aided by deep breathing via resuscitation bag.	**Oxygen equipment** Your cost sharing for Medicare oxygen equipment coverage is **20% coinsurance**, every time you receive equipment. Your cost sharing won't change after you're enrolled for 36 months.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. **You have worldwide emergency care coverage.**	**$100** per Emergency Department visit This copayment does not apply if you are admitted directly to the hospital as an inpatient immediately (it does apply if you are admitted to the hospital as an outpatient; for example, if you are admitted for observation). †If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost sharing you would pay at a network hospital.

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

Covered Service	What you pay
Fitness benefit (One Pass®) A fitness benefit is provided through the One Pass program to help members take control of their health and feel their best. The One Pass program includes: • Gyms and Fitness Locations: You receive a membership with access to a wide variety of in-network gyms through the premium network. Fitness locations include national, local, and community fitness centers and boutique studios. You can use any in-network location, and you may use multiple participating fitness locations during the same month. Participating gyms and fitness centers may vary by location and are subject to change. • Online Fitness: You have access to live, digital fitness classes and on-demand workouts through the One Pass member website or mobile app. • Fitness and Social Activities: You also have access to groups, clubs, and social events through the One Pass member website. • Home Fitness Kits: If you prefer to work out at home, you can also select one home fitness kit per calendar year for Strength, Yoga, or Dance. Kits are subject to change and once selected cannot be exchanged. • Brain Health: Access to online brain health cognitive training programs. For more information about participating gyms and fitness locations, the program's benefits, or to set up your online account, please visit **YourOnePass.com** or call **1-877-614-0618** (TTY **711**), Monday through Friday, 6 a.m. to 7 p.m. The following are not covered: Additional services (such as personal training, fee-based group fitness classes, expanded access hours, or additional classes outside of the standard membership offering). One Pass® is a registered trademark of Optum, Inc. in the U.S. and other jurisdictions and is a voluntary program. The One Pass program and amenities vary by plan, area, and location. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. One Pass is not	**$0**

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

Covered Service	What you pay
responsible for the services or information provided by third parties. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them.	
Health and wellness education programs Health and wellness programs include weight management, quitting tobacco, diabetes management, life care planning, prediabetes, and more. Registered dietitians, health coaches, certified diabetes educators, and other health professionals facilitate our classes. We offer in-person, online, and phone options to fit your learning style. Please see our health and wellness classes and resources catalog at **https://kp.org/healthylivingcatalog/nw**. Contact Member Services for more details or to request a copy of our catalog.	**$0**
Hearing services • Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider • Routine hearing exams	**$35** per visit
• *Hearing aids, including evaluation and fitting.	**Not covered** (If covered, see the Hearing Aid Rider in the **EOC** for additional information.)
HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months. If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home-based palliative care† Services not covered by Medicare in the home are provided in the form of palliative care to diminish symptoms of terminally ill members with a life expectancy of 7–12	**$0**

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

Covered Service	What you pay
months. Services include non-Medicare covered palliative nursing and social work services in the home.	
Home health agency care† Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	**$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 a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • 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. **Note:** The components (such as, Medicare Part B drugs, DME, and medical supplies) needed to perform home infusion may be subject to the applicable cost sharing listed elsewhere in this Medical Benefits Chart depending on the item.
We cover home infusion supplies and drugs if all of the	**$0** **Note:** If a covered home infusion

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

Covered Service	What you pay
following are true: • Your prescription drug is on our Medicare Part D formulary. • We approved your prescription drug for home infusion therapy. • Your prescription is written by a network provider and filled at a network home-infusion pharmacy.	supply or drug is not filled by a network home-infusion pharmacy, the supply or drug may be subject to the applicable cost sharing listed elsewhere in this document depending on the service.
Home medical care not covered by Medicare (Kaiser Permanente at Home)† **This benefit is unavailable to members in Lane County.** We cover medical care in your home that is not otherwise covered by Medicare in certain situations to provide you with an alternative to receiving acute care in a hospital. Services in the home must be: • Prescribed by a network hospitalist who has determined that based on your health status, treatment plan, and home setting that you can be treated safely and effectively in the home • Elected by you because you prefer to receive the care described in your treatment plan in your home Services are provided or arranged by our plan and the providers we contract with to provide the following services and items in your home in accord with your treatment plan for as long as they are prescribed by a network hospitalist: • Home visits by RNs, physical therapists, occupational therapists, speech therapists, respiratory therapists, nutritionist, home health aides, and other healthcare professionals in accord with the home care treatment plan and the provider's scope of practice and license • Communication devices to allow you to contact the medical command center 24 hours a day, 7 days a week. This includes needed communication technology to support reliable communication, and a PERS alert device to contact the medical command center if you are unable to get to a phone • Equipment necessary to ensure that you are monitored appropriately in your home: Blood pressure cuff/monitor, pulse oximeter, scale, and thermometer	**$0**

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

Covered Service	What you pay
• Laboratory tests, mobile imaging (X-rays, ultrasounds), and EKGs • The following safety items: Shower stools, raised toilet seats, grabbers, long handle shoehorn, and sock aid • Meals while you are receiving acute care in the home	
In addition, for Medicare-covered services and items listed below, the cost sharing indicated elsewhere in this Medical Benefits Chart does not apply when the services and items are prescribed as part of your home treatment plan: • Durable medical equipment • Medical supplies • Ambulance transportation to and from network facilities when ambulance transport is medically necessary • The following services at a network facility if the services are part of your home treatment plan: o Network Emergency Department visits associated with this benefit o Radiology services associated with this benefit The cost sharing indicated elsewhere in this Medical Benefits Chart will apply to all other services and items that aren't part of your home treatment plan (for example, DME unrelated to your home treatment plan) or are part of your home treatment plan, but are not provided in your home except as listed above. **Note:** For prescription drug cost sharing information, please refer to the "Medicare Part B drugs" and "Medicare Part D drugs" section in this chart.	**$0**
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, **not** our plan.

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

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

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

Covered Service	What you pay
For services covered by our plan but not covered by Medicare Part A or B: We will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **For drugs that may be covered by our plan's Part D benefit:** If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4. **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.	
Our plan covers hospice consultation services for a terminally ill person who hasn't elected the hospice benefit.	**$0**
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 7, for more information.	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.
Inpatient hospital care† Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	**$500 per admission** Cost-sharing is charged for each inpatient stay. †If you get authorized inpatient care at

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

Covered Service	What you pay
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 aren't limited to: • Semi-private 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 • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If we provide transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion, in accord with our travel and lodging guidelines, which are available from Member Services. • Blood - including storage and administration • Physician services	an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital. **Note:** If you are admitted to the hospital in 2025 and are not discharged until sometime in 2026, the 2025 cost sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility.

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

Covered Service	What you pay
Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Benefits*. This fact sheet is available at **https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf** or by calling **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**.	
Inpatient services in a psychiatric hospital† Covered services include mental health care services that require a hospital stay. • We cover up to 190 days per lifetime for inpatient stays in a Medicare-certified psychiatric hospital. The number of covered lifetime hospitalization days is reduced by the number of inpatient days for mental health treatment previously covered by Medicare in a psychiatric hospital. • The 190-day limit doesn't apply to mental health stays in a psychiatric unit of a general hospital.	**$500 per admission** Cost-sharing is charged for each inpatient stay. **Note:** If you are admitted to the hospital in 2025 and are not discharged until sometime in 2026, the 2025 cost sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility.
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay† If you've used up your inpatient mental health or skilled nursing facility (SNF) benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient or SNF stay. In some cases, we'll cover certain services you get while you're in the hospital or (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices	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.

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Covered Service	What you pay
• Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible people under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B drugs† These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include: • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases	Your applicable Part D prescription drug copayment or coinsurance

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Covered Service	What you pay
• Other 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 • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them. • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does. • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa). • The Alzheimer's drug, Leqembi® (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug. • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar®	

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Covered Service	What you pay
• Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services	**$0 or 15% Coinsurance depending on the drug (please call Member Services to find out which drugs are provided at a Coinsurance)**
• Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug	**15% Coinsurance**
• Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Parenteral and enteral nutrition (intravenous and tube feeding) • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics	**$0**
Note: • We also cover some vaccines under Part B and most adult vaccines under our Part D drug benefit. • Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6 and in the "Medicare Part D drugs" section below.	

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Covered Service	What you pay
***Medicare Part D drugs†** Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6 and listed here.	**$20 generic/$40 preferred brand/$100 non-preferred drug for up to a 30-day supply, per prescription. When you get your drugs from our mail-order pharmacy, you may get up to a 31-90 day supply for two copayments. $100 for specialty drugs for up to a 30-day supply, per prescription. Insulin is subject to the applicable drug tier cost-sharing up to $35 for each 30-day supply. After you have paid $2,100 out-of-pocket for Part D covered drugs in a calendar year, you pay nothing for the remainder of the year.**
***Non-Medicare Part D drugs (enhanced benefit)†**	**Not covered**
Nursing hotline 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 call 1-800-813-2000.	**$0**
	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.

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Covered Service	What you pay
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.	
Opioid treatment program services† Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable)	**$0 or 15% Coinsurance depending on the drug** for clinically administered Medicare Part B drugs when provided by an Opioid Treatment Program
• Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	**$35** per visit
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to: • †Laboratory tests	**$10 per department visit**
o INR lab tests for persons with liver disease or certain bleeding disorders o A1c lab tests for persons with diabetes o LDL lab tests for person with heart disease	**$0**
• Blood - including storage and administration	**$0**
• †X-rays	**$10 per department visit**

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Covered Service	What you pay
• †Diagnostic non-laboratory tests such as electrocardiograms (EKGs), holter monitoring, and electroencephalograms (EEGs) when your doctor or other health care provider orders them to treat a medical problem • Ultrasounds • Sleep studies	
• †Radiation (radium and isotope) therapy including technician materials and supplies	**$25** per visit
• †Surgical supplies, such as dressings • †Splints, casts, and other devices used to reduce fractures and dislocations	**$0** for surgical supplies or casts **20% Coinsurance** for take-home dressings and supplies, splints, and other devices to reduce fractures and dislocations
• Other outpatient diagnostic tests: o †Diagnostic non-laboratory tests such as magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET) when your doctor or other health care provider orders them to treat a medical problem	**$100 per department visit**
• Any other diagnostic tests: o †Any diagnostic test or special procedure that is provided in an outpatient department of a hospital or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort	**$250** per visit
Outpatient hospital observation† Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered	**$100** 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

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Covered Service	What you pay
only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at **https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**.	outpatient surgery.
Outpatient hospital services† We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	**Emergency Department** **$100** per visit **Outpatient surgery** **$250** per visit Refer to the "Outpatient hospital observation" section of this Medical Benefits Chart for the cost sharing applicable to observation services.
• Laboratory and diagnostic tests billed by the hospital • X-rays and other radiology services billed by the hospital	**Lab tests** • **$10 per department visit** **X-rays, ultrasounds, EKG, EEG, sleep studies, and holter monitoring** • **$10 per department visit** **Radiation therapy** • **$25** per visit **MRI, CT, and PET** • **$100 per department visit**

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Covered Service	What you pay
• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it	**$20** per day
• Medical supplies such as splints and casts	**$0** for surgical supplies or casts **20% Coinsurance** for splints or take home dressings and supplies
• Certain drugs and biologicals you can't give yourself	**$0 or 15% Coinsurance depending on the drug (please call Member Services to find out which drugs are provided at a Coinsurance)**
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.	
Outpatient mental health care Covered services include: • Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	• **$20** per individual therapy visit • **$10** per group therapy visit
Outpatient rehabilitation services† Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**$25** per visit (or per day in a CORF)
Outpatient substance use disorder services† Covered services include: Intensive outpatient treatment program.	• **$20** per individual therapy visit • **$10** per group therapy visit

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Covered Service	What you pay
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers† **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	**$250** per visit
Outside service area benefit If you travel outside our service area, but inside the United States or its territories, we cover preventive, routine, follow-up, or continuing care office visits obtained from out-of-network Medicare providers not to exceed **$1,000** in covered Plan Charges per calendar year. We will pay up to 80% of the Medicare allowable charge, if the provider accepts assignment. Otherwise, we will pay 80% of the Medicare limiting charge, if the provider does not accept assignment.	**20%** of the Medicare allowable or limiting charges, and any amounts that exceed **$1,000** in Plan Charges per calendar year
Partial hospitalization services and intensive outpatient services† Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT),	**$20** per day

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Covered Service	What you pay
or licensed professional counselor's office but less intense than partial hospitalization.	
Physician/Practitioner services, including doctor's office visits Covered services include: • †Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • †Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your network provider, if your doctor orders it to see if you need medical treatment • †Second opinion by another network provider prior to surgery • †Nonroutine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	**Note:** Cost sharing is charged based on the medical department where the service is provided, not the type of provider. In addition, multiple copayments may apply, depending on services provided and whether a consultation occurs. **Primary care office visits** • **$30** per visit **Specialist office visits** • **$35** per visit **Outpatient hospital department or surgical center** You pay the following per visit 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: • **$250**
• Chemotherapy visits	**$25** per visit
• †Ultraviolet light treatments	**$5** per visit
• †Visits for injections administered in outpatient settings	**$10** per injection

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Covered Service	What you pay
• Certain telehealth services, including: Primary and specialty care, which includes inpatient hospital acute, inpatient hospital psychiatric, cardiac rehabilitation services, emergency services, urgently needed services, home health services, occupational therapy, mental health, podiatry services, psychiatric services, physical therapy and speech-language pathology services, diagnostic procedures and tests, outpatient substance abuse, dialysis services, kidney disease education services, diabetes self-management training, nutritional/dietary benefit, health education, naturopathy visits, 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. o You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. We offer the following means of telehealth: ▪ Interactive video visits for professional services when care can be provided in this format as determined by a network provider ▪ Scheduled telephone appointment visits for professional services when care can be provided in this format as determined by a network provider • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:	**$0**

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Covered Service	What you pay
o You have an in-person visit within 6 months prior to your first telehealth visit o You have an in-person visit every 12 months while getting these telehealth services o Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: o You're not a new patient and o The check-in isn't related to an office visit in the past 7 days and o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: o You're not a new patient and o The evaluation isn't related to an office visit in the past 7 days and o The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record	
Podiatry services† Covered services include: • 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	**Specialist office visits** • **$35** per visit **Outpatient hospital department or surgical center** You pay the following per visit 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

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Covered Service	What you pay
	reduce sensation or minimize discomfort: • **$250**
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months • Up to 8 HIV screenings every 12 months • A one-time hepatitis B virus screening	There is no coinsurance, copayment, or deductible for the PrEP benefit.
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual digital rectal exam or PSA test.
Prosthetic and orthotic devices and related supplies† Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to "Vision Care" later in this table for	**20% Coinsurance** for external prosthetic or orthotic devices and supplies (including wound care supplies) **$0** for surgically implanted internal devices and enteral and parenteral nutrition therapy

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Covered Service	What you pay
more detail. Includes wigs following chemotherapy or radiation therapy (up to one synthetic wig per year).	
Pulmonary rehabilitation services† Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**$20** per visit
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.	**$250 per admission** Cost-sharing is charged per admission to a residential treatment program.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

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Covered Service	What you pay
brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	
Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945–1965. If you were born between 1945–1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.
Screening for lung cancer with low-dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months. Eligible members are people age 50–77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. For LDCT lung cancer screenings after the initial LDCT screening: the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

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Covered Service	What you pay
Medicare criteria for such visits.	
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease† Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care.	**$0**
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible)	**$0**
• 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 check your dialysis equipment and water supply)	**$0**
• Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care)	No additional charge for services received during a hospital stay. Refer to the "Inpatient hospital care" section

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Covered Service	What you pay
	of this Medical Benefits Chart for the cost sharing applicable to inpatient stays.
Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to "Medicare Part B drugs" in this table.	
Skilled nursing facility (SNF) care† (For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) We cover **up to 100 days per benefit period of** skilled inpatient services in a skilled nursing facility in accord with Medicare guidelines (a prior hospital stay is not required). Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of our 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 • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.	**$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. **Note:** If a benefit period begins in 2025 for you and does not end until sometime in 2026, the 2025 cost sharing will continue until the benefit period ends.

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Covered Service	What you pay
• A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year).	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Supervised Exercise Therapy (SET)† SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30–60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques	**$20** per visit

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

Covered Service	What you pay
SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. • **Inside our service area:** You must obtain urgent care from network providers, unless our provider network is temporarily unavailable or inaccessible due to an unusual and extraordinary circumstance (for example, major disaster). • **Outside our service area:** You have worldwide urgent care coverage when you travel if you need medical attention right away for an unforeseen illness or injury and you reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our service area. **See Chapter 3, Section 3, for more information.**	**Office visits** **$35** per visit **Emergency Department visits** **$100** 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	**$35** per visit
• Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. However, our plan does cover the following exams:	**$20** per visit

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

Covered Service	What you pay
♦ 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 for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered.	**$0**
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. • Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant	**$0** for eyewear in accord with Medicare guidelines ***Note:** If the eyewear you purchase costs more than what Medicare covers, you pay the difference.
• *Prescription eyewear (eyeglass lenses, eyeglass frames, and contact lenses)	**Balance after $100 allowance to use toward the purchase price of eyewear once within a two-calendar-year period** (If covered, see the Prescription Eyewear Rider in the **EOC** for additional information.)
Welcome to Medicare preventive visit Our plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to*	There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit.

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

Covered Service	What you pay
Medicare preventive visit.	
Note: Refer to Chapter 1 (Section 6) and Chapter 11 (Section 9) for information about coordination of benefits that applies to all covered services described in this Medical Benefits Chart.	

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

January 1 – December 31, 2026

Evidence of Coverage for 2026

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

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

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

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

For questions about this document, **call Member Services at 1-877-221-8221 (TTY users call 711). Hours are 8 a.m. to 8 p.m., 7 days a week. This call is free.**

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

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

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2027.

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

KAISER PERMANENTE®

2026 Evidence of Coverage

Table of Contents

Chapter 1 — Get started as a member 47

Section 1 — You're a member of our plan 47

Section 2 — Plan eligibility requirements 47

Section 3 — Important membership materials 51

Section 4 — Costs 52

Section 5 — Keep our plan membership record up to date 55

Section 6 — How other insurance works with our plan 55

Chapter 2 — Phone numbers and resources 57

Section 1 — Kaiser Permanente Senior Advantage contacts 57

Section 2 — Get help from Medicare 59

Section 3 — State Health Insurance Assistance Program (SHIP) 60

Section 4 — Quality Improvement Organization (QIO) 61

Section 5 — Social Security 62

Section 6 — Medicaid 63

Section 7 — Programs to help people pay for prescription drugs 64

Section 8 — Railroad Retirement Board (RRB) 66

Section 9 — If you have group insurance or other health insurance from an employer 67

Chapter 3 — Using our plan for your medical services 68

Section 1 — How to get medical care as a member of our plan 68

Section 2 — Use providers in our plan's network to get medical care 69

Section 3 — How to get services in an emergency, disaster, or urgent need for care 74

Section 4 — What if you're billed directly for the full cost of covered services? 76

Section 5 — Medical services in a clinical research study 76

Section 6 — Rules for getting care in a religious non-medical health care institution 78

Section 7 — Rules for ownership of durable medical equipment 79

Chapter 4 — Medical Benefits Chart (what's covered and what you pay).....81

Section 1 — Understanding your out-of-pocket costs for covered services.....81

Section 2 — The Medical Benefits Chart shows your medical benefits and costs.....82

Section 3 — Services that aren't covered by our plan (exclusions).....83

Chapter 5 — Using plan coverage for Part D drugs 88

Section 1 — Basic rules for our plan's Part D coverage.....88

Section 2 — Fill your prescription at a network pharmacy or through our plan's mail-order service 88

Section 3 — Your drugs need to be on our plan's Drug List 91

Section 4 — Drugs with restrictions on coverage.....92

Section 5 — What you can do if one of your drugs isn't covered the way you'd like 93

Section 6 — Our Drug List can change during the year.....95

Section 7 — Types of drugs we don't cover 97

Section 8 — How to fill a prescription 98

Section 9 — Part D drug coverage in special situations.....98

Section 10 — Programs on drug safety and managing medications.....99

Chapter 6 — What you pay for Part D drugs 102

Section 1 — What you pay for Part D drugs 102

Section 2 — Drug payment stages for our plan members 103

Section 3 — Your Part D Explanation of Benefits (EOB) explains which payment stage you're in.....104

Section 4 — The Deductible Stage.....105

Section 5 — The Initial Coverage Stage.....105

Section 6 — The Catastrophic Coverage Stage.....107

Section 7 — What you pay for Part D vaccines 107

Chapter 7 — Asking us to pay our share of a bill for covered medical services or drugs 110

Section 1 — Situations when you should ask us to pay our share for covered services or drugs 110

Section 2 — How to ask us to pay you back or pay a bill you got 112

Section 3 — We'll consider your request for payment and say yes or no..... 113

Chapter 8 — Your rights and responsibilities 114

Section 1 — Our plan must honor your rights and cultural sensitivities 114

Section 2 — Your responsibilities as a member of our plan 118

Chapter 9 — If you have a problem or complaint (coverage decisions, appeals, complaints) 120

Section 1 — What to do if you have a problem or concern..... 120

Section 2 — Where to get more information and personalized help 120

Section 3 — Which process to use for your problem 121

Section 4 — A guide to coverage decisions and appeals..... 121

Section 5 — Medical care: How to ask for a coverage decision or make an appeal 124

Section 6 — Part D drugs: How to ask for a coverage decision or make an appeal..... 130

Section 7 — How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon 138

Section 8 — How to ask us to keep covering certain medical services if you think your coverage is ending too soon..... 142

Section 9 — Taking your appeal to Levels 3, 4, and 5 145

Section 10 — How to make a complaint about quality of care, waiting times, customer service, or other concerns 148

Chapter 10 — Ending membership in our plan 151

Section 1 — Ending your membership in our plan..... 151

Section 2 — When can you end your membership in our plan?..... 151

Section 3 — How to end your membership in our plan..... 152

Section 4 — Until your membership ends, you must keep getting your medical items, services, and drugs through our plan 152

Section 5 — We must end our plan membership in certain situations 152

Chapter 11 — Legal notices 155

Section 1 — Notice about governing law 155

Section 2 — Notice about nondiscrimination 155
Section 3 — Notice about Medicare Secondary Payer subrogation rights 155
Section 4 — Administration of this Evidence of Coverage 155
Section 5 — Amendment of Agreement 156
Section 6 — Applications and statements 156
Section 7 — Assignment 156
Section 8 — Attorney and advocate fees and expenses 156
Section 9 — Coordination of benefits 156
Section 10 — Employer responsibility 156
Section 11 — Evidence of Coverage binding on members 157
Section 12 — Government agency responsibility 157
Section 13 — Member nonliability 157
Section 14 — No waiver 157
Section 15 — Notices 157
Section 16 — Overpayment recovery 157
Section 17 — Third party liability 157
Section 18 — U.S. Department of Veterans Affairs 158
Section 19 — Workers' compensation or employer's liability benefits 159
Section 20 — Surrogacy 159

Chapter 12 — Definitions 160

Chapter 1 — Get started as a member

Section 1 — You're a member of our plan

Section 1.1 – You're enrolled in our plan, which is a Medicare HMO plan

You're covered by Medicare, and you chose to get your Medicare health and your drug coverage through our plan, Kaiser Permanente Senior Advantage.

Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

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

Section 1.2 – Legal information about the Evidence of Coverage

This **Evidence of Coverage (EOC)** explains what our plan covers, in addition to your enrollment form, the **2026 Comprehensive Formulary**, and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called **riders** or **amendments**.

If your group renews on January 1, the **Evidence of Coverage** is in effect for the months you're enrolled in our plan between January 1, 2026, and December 31, 2026, unless amended.

If your group's **Agreement** renews at a later date in 2026, the term of this **Evidence of Coverage** is during that contract period, unless amended.

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

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 only as long as your group continues to offer this plan, we choose to continue offering our plan and Medicare renews approval of our plan.

Section 2 — Plan eligibility requirements

Section 2.1 – Eligibility requirements

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

- You have both Medicare Part A and Medicare Part B.
- You live in our geographic service area (described in Section 2.4). People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it.
- You're a United States citizen or lawfully present in the United States.

Note: If you are enrolled in a Medicare plan and lose Medicare eligibility, you may be able to enroll under your group's non-Medicare plan if that is permitted by your group (please ask your group for details).

Section 2.2 – Group eligibility requirements

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

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

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

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

If you are a subscriber enrolled under this **Evidence of Coverage** or a subscriber enrolled in a non-Medicare plan offered by your group, the following persons may be eligible to enroll as your dependents under this **Evidence of Coverage** if they meet all the other requirements described under this Section 2:

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

We may request proof of incapacity and dependency annually.

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

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

Note: If you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this **Evidence of Coverage**, you may be able to enroll them as your dependents under a non-Medicare plan offered by your group. Please contact your group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

Section 2.3 – When you can enroll and when coverage begins

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

- Your group may have additional requirements that we have approved, which allow enrollment in other situations.
- The effective date of your Senior Advantage coverage under this **Evidence of Coverage** must be confirmed by the Centers for Medicare & Medicaid Services (CMS), as described in this Section 2.3.

If you are eligible to be a dependent under this **Evidence of Coverage** but the subscriber in your family is enrolled under a non-Medicare plan offered by your group, the subscriber must follow the rules applicable to subscribers who are enrolling dependents in this Section 2.3.

New subscribers

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

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

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

Adding new dependents to an existing account

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

newly acquired dependents is determined by your group, subject to confirmation by CMS.

Group open enrollment

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

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless you experience a qualifying event as defined in applicable federal law. Examples of qualifying events include, but are not limited to:

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

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

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

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

Section 2.4 – Plan service area for our plan

Our plan is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our service area. The service area is described below:

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

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

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

If you move out of our plan's service area, you can't stay a member of this plan.

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

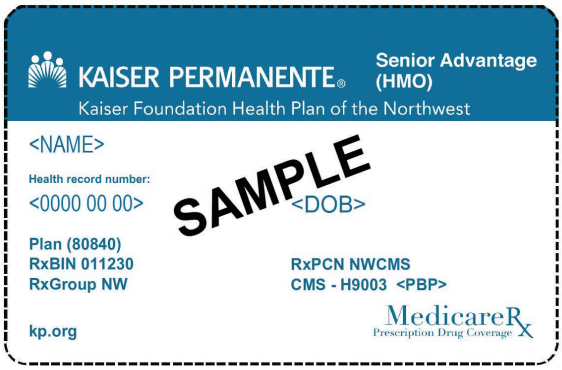
Section 2.5 – U.S. citizen or lawful presence

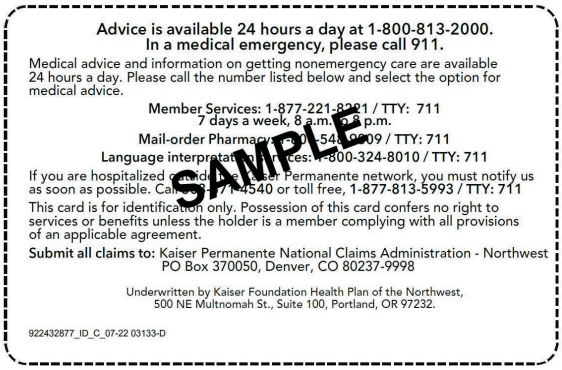
You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify us if you're not eligible to stay a member of our plan on this basis. We must disenroll you if you don't meet this requirement.

Section 3 — Important membership materials

Section 3.1 – Our plan membership card

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





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

If our plan membership card is damaged, lost, or stolen, call Member Services at 1-877-221-8221 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 – Provider Directory

The **Provider Directory** at **kp.org/directory** lists our current network providers and durable medical equipment suppliers.

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

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

The most recent list of providers and suppliers is available on our website at **kp.org/directory**.

If you don't have a **Provider Directory**, you can ask for a copy (electronically or in paper form) from Member Services at 1-877-221-8221 (TTY users call 711). Requested paper Provider Directories will be mailed to you within 3 business days.

Section 3.3 – Pharmacy Directory

The **Pharmacy Directory** at **kp.org/directory** lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the **Pharmacy Directory** to find the network pharmacy you want to use. Go to Chapter 5, Section 2.4, for information on when you can use pharmacies that aren't in our plan's network.

If you don't have a **Pharmacy Directory**, you can ask for a copy from Member Services at 1-877-221-8221 (TTY users call 711). You can also find this information on our website at **kp.org/directory**.

Section 3.4 – Drug List (formulary)

Our plan has a **2026 Comprehensive Formulary** (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit included in *our plan*. The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed and replaced as described in Chapter 5, Section 6. Medicare approved our plan's Drug List.

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

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit **kp.org/seniorrx** or call Member Services at 1-877-221-8221 (TTY users call 711).

Section 4 — Costs

Your costs may include the following:

- Plan Premium (Section 4.1).
- Monthly Medicare Part B Premium (Section 4.2).
- Part D Late Enrollment Penalty (Section 4.3).
- Income Related Monthly Adjusted Amount (Section 4.4).
- Medicare Prescription Payment Plan Amount (Section 4.5).

Section 4.1 – Plan Premium

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

Section 4.2 – Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums
You must continue paying your Medicare premiums to stay a member of our plan. This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

Section 4.3 – Part D Late Enrollment Penalty

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

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

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

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

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, our plan will count the number of full months you didn't have coverage. The penalty is 1% for every month you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty percentage will be 14%.

- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2026, this average premium amount is $38.99.
- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium and round it to the nearest 10 cents. In the example here, it would be 14% times $38.99, which equals $5.45. This rounds to $5.50. **This amount would be added to the monthly plan premium for someone with a Part D late enrollment penalty.**

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

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

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

Section 4.4 – Income Related Monthly Adjustment Amount

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

If you have to pay an extra IRMAA, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you'll get a bill from Medicare. **If you don't pay the extra IRMAA, you'll be disenrolled from our plan and lose prescription drug coverage.**

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

Section 4.5 – Medicare Prescription Payment Plan Amount

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

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

Section 5 — Keep our plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage including your Primary Care Provider.

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

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

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

If any of this information changes, let us know by calling Member Services at 1-877-221-8221 (TTY users call 711).

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

Section 6 — How other insurance works with our plan

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

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read over this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services at

1-877-221-8221 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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

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

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

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

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

Chapter 2 — Phone numbers and resources

Section 1 — Kaiser Permanente Senior Advantage contacts

For help with claims, billing, or member card questions, call or write to our plan's Member Services at 1-877-221-8221 (TTY users call 711). We'll be happy to help you.

	Member Services – Contact Information
Call	**1-877-221-8221** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services at 1-877-221-8221 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
Write	Kaiser Permanente Member Services 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099
Website	**kp.org**

How to ask for a coverage decision about your medical care

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

	Coverage Decisions for Medical Care – Contact Information
Call	**1-877-221-8221** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
Write	Kaiser Permanente Attn: Utilization Management 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099

	Coverage Decisions for Medical Care – Contact Information
Website	**kp.org**

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

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

	Coverage Decisions for Part D Drugs – Contact Information
Call	**1-888-791-7245** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
Fax	**1-844-403-1028**
Write	OptumRx c/o Prior Authorization P.O. Box 2975 Mission, KS 66201
Website	**kp.org**

How to make an appeal or complaint about your medical care or Part D drugs

An appeal is a formal way of asking us to review and change a coverage decision. You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to ask for an appeal or make a complaint about your medical care or Part D drugs, go to Chapter 9.

	Appeals or Complaints about Medical Care or Part D Drugs – Contact Information
Call	**1-877-221-8221** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.

	Appeals or Complaints about Medical Care or Part D Drugs – Contact Information
Fax	**1-855-347-7239**
Write	Kaiser Permanente Member Relations 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099
Medicare Website	To submit a complaint about our plan directly to Medicare go to **www.Medicare.gov/my/medicare-complaint**

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

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

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

	Payment Requests – Contact Information
Call	**1-877-221-8221** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
Write	Kaiser Permanente Claims Department Northwest Region P.O. Box 370050 Denver, CO 80237-9998
Website	**kp.org**

Section 2 — Get help from Medicare

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services

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

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

Section 3 — State Health Insurance Assistance Program (SHIP)

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

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

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

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

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

	Senior Health Insurance Benefits Assistance (Oregon's SHIP) – Contact Information	**Statewide Health Insurance Benefits Advisors (Washington's SHIP) – Contact Information**
Call	**1-800-722-4134**	**1-800-562-6900**
TTY	**711**	**1-360-586-0241** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Oregon SHIBA 500 Summer St. NE, E-12 Salem, OR 97301	Washington SHIBA P.O. Box 40255 Olympia, WA 98504-0255
Website	**shiba.oregon.gov**	**insurance.wa.gov/shiba**

Section 4 — Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For Oregon and Washington, the Quality Improvement Organization is called Acentra Health.

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

Contact Acentra Health in any of these situations:

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

	Acentra Health (Oregon's and Washington's Quality Improvement Organization) – Contact Information
Call	**1-888-305-6759** Calls to this number are free. Monday through Friday, 9 a.m. to 5 p.m. Weekends and holidays, 11 a.m. to 3 p.m.
TTY	**711**
Write	Acentra Health 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317
Website	**www.acentraqio.com**

Section 5 — Social Security

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

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

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

	Social Security – Contact Information
	who have difficulties with hearing or speaking. Calls to this number are free. Available 8 a.m. to 7 p.m., Monday through Friday.
Website	**www.ssa.gov**

Section 6 — Medicaid

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

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

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

To find out more about Medicaid and Medicare Savings Programs, contact Oregon's or Washington's Medicaid program.

	Oregon Health Plan – Contact Information	Washington State Department of Social and Health Services – Contact Information
Call	**1-800-273-0557** Monday – Friday, 8 a.m. – 5 p.m.	**1-877-501-2233** Monday – Friday, 8 a.m. – 5 p.m.
TTY	**711**	**711**
Write	Division of Medical Assistance Programs 500 Summer St. NE Salem, OR 97301	Department of Social and Health Services 1115 Washington St. SE Olympia, WA 98504

	Oregon Health Plan – Contact Information	Washington State Department of Social and Health Services – Contact Information
Website	**healthcare.oregon.gov**	**www.washingtonconnection.org/home/**

Section 7 — Programs to help people pay for prescription drugs

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

Extra Help from Medicare

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

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

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

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

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

If you aren't sure what evidence to provide us, 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 get the evidence showing the right copayment level, we'll update our system so you can pay the right amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make the payment directly to the state. Call Member Services at 1-877-221-8221 (TTY users call 711) if you have questions.

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

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

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status.

If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, Oregon residents, call **1-800-805-2313**, and Washington residents, call **1-877-376-9316**.

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** To learn more about this payment option, call Member Services at 1-877-221-8221 (TTY users call 711) or visit www.Medicare.gov.

	Medicare Prescription Payment Plan – Contact Information
Call	**1-877-221-8221** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services at 1-877-221-8221 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m
Write	Kaiser Permanente Member Services 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099
Website	**kp.org**

Section 8 — Railroad Retirement Board (RRB)

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

	Railroad Retirement Board (RRB) – contact information
Call	**1-877-772-5772** Calls to this number are free. Press "0," to speak with an RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9 a.m. to 12 p.m. on

	Railroad Retirement Board (RRB) – contact information
	Wednesday. Press "1," to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	**1-312-751-4701** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren't free.
Website	**https://rrb.gov/**

Section 9 — If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at 1-877-221-8221 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can call **1-800-MEDICARE** (**1-800-633-4227**) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's benefits administrator**. The benefits administrator can help you understand how your current drug coverage will work with our plan.

Chapter 3 — Using our plan for your medical services

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

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get you get care, go to the Medical Benefits Chart found at the front of this **EOC**.

Section 1.1 – Network providers and covered services

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

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

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

We will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart** found at the front of this **EOC**.
- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 for more information).
  - In most situations, your network PCP must give you approval in advance (a referral) before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information, go to Section 2.3.
  - You don't need referrals from your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2.

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

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

Section 2.1 – You must 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 must choose one of our available network providers to be your primary care provider. Your primary care provider is a physician who meets state requirements and is trained to give you primary medical care. Your PCP will usually practice general medicine (also called adult or internal medicine and family practice). At some network facilities, if you prefer, you may choose an available nurse practitioner or physician assistant to be your primary care provider. PCPs are identified in the **Provider Directory**.

Your PCP provides, prescribes, or authorizes medically necessary covered services. Your PCP will provide most of your routine or basic care and provide a referral as needed to see other network providers for other care you need. For example, to see a specialist, you usually need to

get your PCP's approval first (this is called getting a "referral" to a specialist). There are a few types of covered services you can get on your own without contacting your PCP first (see Section 2.2 in this chapter).

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

How to choose or change your PCP

As explained above, your PCP plays an important role in your health care. That's why we require you to have a PCP. If you do not select a PCP when you enroll, we will assign you a PCP or primary care team and notify you accordingly. You may change your PCP for any reason and at any time from our available PCPs, including if you need to select a new PCP because your PCP isn't part of our network of providers any longer. Your PCP selections will be effective immediately.

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

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

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

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

- Routine women's health care, including breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider
- Flu shots, COVID-19 vaccines, Hepatitis B vaccines, and pneumonia vaccines, as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area. If possible, call Member Services at 1-877-221-8221 (TTY users call 711) before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.
- Second opinions from another network provider except for certain specialty care

- Medicare-covered preventive care as specified in the Medical Benefits Chart found at the front of this **EOC**
- Outpatient care for mental health at network Mental Health Departments
- Routine vision exams
- Routine hearing exams
- Cancer counseling

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

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

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

Referrals from your PCP

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

Referrals to network providers

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

Prior authorization

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

- Services and items identified in the Medical Benefits Chart found at the front of this **EOC** with a footnote (†).

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

When a specialist or another network provider leaves our plan

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

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
  - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
  - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.

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

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

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

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

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

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

Section 3.1 – Get care if you have a medical emergency

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

If you have a medical emergency:

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

Covered services in a medical emergency

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

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

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

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

What if it wasn't a medical emergency?

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

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

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

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

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

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. Whether you 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 call **1-800-813-2000**.

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

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

Section 3.3 – Get care during a disaster

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

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

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing. If you can't use a network pharmacy during a disaster, you may be able to fill your prescriptions at an out-of-network pharmacy. Go to Chapter 5, Section 2.4.

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

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

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

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

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

Section 5 — Medical services in a clinical research study

Section 5.1 – What is a clinical research study

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

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

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

exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

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

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

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

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

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

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

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

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

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

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication **Medicare and Clinical Research Studies**, available at **https:/www.medicare.gov/sites/default/files/2019-09/0226-medicare-and-clinical-research-studies.pdf.** You can also call **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**.

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

Section 6.1 – A religious non-medical health care institution

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

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

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

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

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

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

Note: Covered services are subject to the same limitations and cost-sharing required for services provided by network providers as described in Chapter 4, the Medical Benefits Chart found at the front of this **EOC**, and Chapter 12.

Section 7 — Rules for ownership of durable medical equipment

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

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

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

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

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

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

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

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

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

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

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

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

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5

years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

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

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

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

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

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

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

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

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

Medicare Advantage Plans have limits on the total amount you have to pay out of pocket each year for in-network medical services covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2026 the MOOP amount can be found in the Medical Benefits Chart at the front of this EOC.**

The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for Part D drugs don’t count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services don’t count toward your maximum out-of-pocket amount. These services are marked with an asterisk (*) in the Medical Benefits Chart found at the front of this **EOC**. If you reach the maximum out-of-pocket amount stated in the Medical Benefits Chart at the front of the **EOC**, you won’t have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium

(unless your Part B premium is paid for you by Medicaid or another third party).

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

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

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15), you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
  - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
  - If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or for urgently needed services outside the service area.)
- If you think a provider has balance billed you, call Member Services at 1-877-221-8221 (TTY users call 711).

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

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

- Your Medicare-covered services must be provided according to the Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. **Medically necessary** means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

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

Other important things to know about our coverage:

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

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

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

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

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

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances.
Care in an intermediate or residential care facility, assisted living facility, or adult foster home	Covered as described in "Residential substance use disorder and mental health treatment" section of the Medical Benefits Chart.
Conception by artificial means, such as in vitro fertilization, zygote intrafallopian transfers, ovum transplants, and gamete intrafallopian transfers (except artificial insemination and related services covered by Medicare)	Not covered under any condition.
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care Custodial care is personal care that 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	Not covered under any condition.
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance)	Covered if medically necessary and covered under Original Medicare.

Services not covered by Medicare	Covered only under specific conditions
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	May be covered by Original Medicare under a Medicare-approved clinical research study. (Go to Chapter 3, Section 5, for more information on clinical research studies.)
Eyeglasses and contact lenses	One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens.
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition.
Full-time nursing care in your home	Not covered under any condition.
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	Not covered under any condition.
Licensed ambulance services without transport	Covered if the ambulance transports you or if covered by Medicare.
Massage therapy	Covered when ordered as part of physical therapy program in accord with Medicare guidelines.
Naturopath services (uses natural or alternative treatments)	Not covered under any condition.
Nonconventional intraocular lenses (IOLs) following cataract surgery (for example, a presbyopia-correcting IOL)	Not covered under any condition.
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care.

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

Services not covered by Medicare	Covered only under specific conditions
Services considered not reasonable and necessary, according to Original Medicare standards	This exclusion doesn't apply to services or items that aren't covered by Original Medicare but are covered by our plan.
Services provided to veterans in Veterans Affairs (VA) facilities	When emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we 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	Not covered under any condition.
Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a network provider	Not covered under any condition.
Travel and lodging expenses/living expenses	We may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines for transplants. Your transplant coordinator can provide information about covered expenses.

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

Chapter 5 — Using plan coverage for Part D drugs

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

Go to the Medical Benefits Chart found at the front of this EOC for Medicare Part B drug benefits and hospice drug benefits.

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription, that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription (go to Section 2), you can fill your prescription through our plan's mail-order service.
- Your drug must be on our plan's **2026 Comprehensive Formulary** (go to Section 3)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 in this chapter for more information)

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

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

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

Section 2.1 – Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your **Pharmacy Directory**, visit our website (**kp.org/directory**), and/or call Member Services at 1-877-221-8221 (TTY users call 711).

You may go to any of our network pharmacies.

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. To find another pharmacy in your area, get help from Member Services at 1-877-221-8221 (TTY users call 711) or use the **Pharmacy Directory**. You can also find information on our website at **kp.org/directory**.

Specialized pharmacies

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting Part D drugs in an LTC facility, call Member Services at 1-877-221-8221 (TTY users call 711).
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network. I/T/U pharmacies must be within our service area.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. To locate a specialized pharmacy, go to your **Pharmacy Directory at kp.org/directory** or call Member Services at 1-877-221-8221 (TTY users call 711).

Section 2.2 – Our plan's mail-order service

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

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

To get information about filling your prescriptions by mail, visit your local Kaiser Permanente pharmacy or call **1-800-548-9809 (**TTY 7**11)**, Monday through Friday, 8 a.m. to 5:30 p.m. You can conveniently order your prescription refills in the following ways:

- Register and order online securely at **kp.org/refill**.
- Call the mail-order pharmacy toll free at **1-800-548-9809** (TTY 7**11**), Monday through Friday, 8 a.m. to 5:30 p.m.
- Mail your prescription or refill request on a mail order form available at any Kaiser Permanente pharmacy.

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

retail pharmacy instead of from our mail-order pharmacy.

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

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

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

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your **Pharmacy Directory** at **kp.org/directory** tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services at 1-877-221-8221 (TTY users call 711) for more information.
2. You can also get maintenance drugs through our mail-order program. Go to Section 2.2 for more information.

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

Generally, we cover drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. **Check first with Member Services at 1-877-221-8221 (TTY users call 711)** to see if there's a network pharmacy nearby.

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

- If you 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.

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse

you for our share of the cost. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

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

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

Our plan has a **2026 Comprehensive Formulary**. In this **Evidence of Coverage, we call it the Drug List**.

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

The Drug List only shows drugs covered under Medicare Part D.

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

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

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

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

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

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

Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

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

- In some cases, you may be able to get a drug that's not on the Drug List. (For more information, go to Chapter 9.)

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

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

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

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

The amount you pay for drugs is shown in the Medical Benefits Chart found at the front of this **EOC**.

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

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

- Check the most recent Drug List we provided electronically.
- Visit our plan's website **(kp.org/seniorrx)**. The Drug List **(2026 Comprehensive Formulary**) on the website is always the most current.
- Call Member Services at 1-877-221-8221 (TTY users call 711) to find out if a particular drug is on our plan's Drug List (**2026 Comprehensive Formulary**) or ask for a copy of the list. .
- Use our plan's "Real-Time Benefit Tool" (**kp.org/seniorrx**)to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Member Services at 1-877-221-8221 (TTY users call 711).

Section 4 — Drugs with restrictions on coverage

Section 4.1 – Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules

are designed to encourage you and your provider to use that lower-cost option.

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

Section 4.2 – Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Member Services at 1-877-221-8221 (TTY users call 711) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (Go to Chapter 9.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Member Services at 1-877-221-8221 (TTY users call 711) or on our website at **kp.org/seniorrx**.

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

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

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

If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.
If your drug isn't on the Drug List or is restricted, here are options for what you can do:

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

You may be able to get a temporary supply

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

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

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

For questions about a temporary supply, call Member Services at 1-877-221-8221 (TTY users call 711).

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

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Member Services at 1-877-221-8221 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

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

If you and your provider want to ask for an exception, go to Chapter 9, Section 6.4 to learn

what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

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

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Member Services at 1-877-221-8221 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you**.**

You can ask for an exception

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

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

Drugs in our specialty tier (Tier 5) aren't eligible for this type of exception. We don't lower the cost-sharing amount for drugs in this tier.

Section 6 — Our Drug List can change during the year

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

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

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

Information on changes to drug coverage

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

Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and <u>immediately</u> removing or making changes to a like drug on the Drug List.**

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

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

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

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

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

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

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

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

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

Section 7 — Types of drugs we don't cover

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

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

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

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

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

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain

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

We offer additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. The amount you pay for these drugs doesn't count towards qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 6.)

If you **get Extra Help from Medicare** to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. (Go to our plan's Drug List or call Member Services at 1-877-221-8221 (TTY users call 711) for more information. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

Section 8 — How to fill a prescription

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

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

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

Section 9 — Part D drug coverage in special situations

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

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

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

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

Check your **Pharmacy Directory (kp.org/directory)** to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Member Services at 1-877-221-8221 (TTY users call 711). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

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

Section 9.3 – Special note about creditable coverage

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

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

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

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

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

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

Section 10 — Programs on drug safety and managing medications

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

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

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

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

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

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

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

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

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

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

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

We have a program that can help our members with complex health needs.

Our program is called a Medication Therapy Management (MTM) program. This program is

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

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

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

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Member Services at 1-877-221-8221 (TTY users call 711).

Chapter 6 — What you pay for Part D drugs

Section 1 — What you pay for Part D drugs

If you're in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs does not apply to you.** We sent you a separate insert, called the **Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs** (also known as the **Low-Income Subsidy Rider or the LIS Rider**), which tells you about your drug coverage. If you don't have this insert, call Member Services at 1-877-221-8221 (TTY users call 711) and ask for the **LIS Rider.**

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

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5 explains these rules. When you use our plan's "Real-Time Benefit Tool" to look up drug coverage (kp.org/seniorrx), the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided by the "Real-Time Benefit Tool" by calling Member Services at 1-877-221-8221 (TTY users call 711).

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

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

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

Section 1.2 – How Medicare calculates your out-of-pocket costs

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

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

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

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

Moving to the Catastrophic Coverage Stage:

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

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

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

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

Reminder: If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling Member Services at 1-877-221-8221 (TTY users call 711).

Tracking your out-of-pocket total costs

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

Section 2 — Drug payment stages for our plan members

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

- **Stage 1: Yearly Deductible Stage (Because there is no deductible for our plan, this payment stage does not apply to you.)**
- **Stage 2: Initial Coverage Stage**

- **Stage 3: Catastrophic Coverage Stage**

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

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

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

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

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

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

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

- **Show your membership card every time you get a prescription filled**. This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need**. There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
  - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.

  - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
  - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
  - If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.

Check the written report we send you. When you get the **Part D EOB**, look it over to be sure the information is complete and correct. If you think something is missing or you have questions, call Member Services at 1-877-221-8221 (TTY users call 711). You can also choose to view your **Part D EOB** online instead of by mail. Please visit **kp.org/goinggreen** and sign on to learn more about choosing to view your **Part D EOB** securely online. Be sure to keep these reports.

Section 4 — The Deductible Stage

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

Section 5 — The Initial Coverage Stage

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

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

Our plan has six cost-sharing tiers

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

- Cost-sharing **Tier 1** for preferred generic drugs (this tier includes some brand-name drugs).
- Cost-sharing **Tier 2** for generic drugs (this tier includes some brand-name drugs).
- Cost-sharing **Tier 3** for preferred brand-name drugs (this tier includes both generic and brand-name drugs).
- Cost-sharing **Tier 4** for nonpreferred drugs (this tier includes both generic and brand-name drugs).

- Cost-sharing **Tier 5** for specialty-tier drugs (this tier includes both generic and brand-name drugs).
- Cost-sharing **Tier 6** for injectable Part D vaccines (this tier includes only brand-name drugs).

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

Your pharmacy choices

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

- A network retail pharmacy
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.4, to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- Our plan's mail-order pharmacy

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

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

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

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

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

You won't pay more than **$35** for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Go to Section 7 of this chapter for more information on cost sharing for Part D vaccines.

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

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

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

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

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

Section 5.4 – Your costs for a long-term up to a 90-day supply of a covered Part D drug

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

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

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

You won't pay more than **$70** for up to a 2-month supply or **$105** for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier.

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

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

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

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

We'll let you know if you reach this amount. Go to Section 1.2 for more information on how Medicare calculates your out-of-pocket costs.

Section 6 — The Catastrophic Coverage Stage

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

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

Section 7 — What you pay for Part D vaccines

Important message about what you pay for vaccines - Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find

these vaccines listed in our plan's **2026 Comprehensive Formulary**. Our plan covers most adult Part D vaccines at no cost to you.

Go to our plan's **2026 Comprehensive Formulary** or call Member Services at 1-877-221-8221 (TTY users call 711) for coverage and cost-sharing details about specific vaccines**.**

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

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

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

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

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

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

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

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

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

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

- When you get the vaccine, you may have to pay the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.

- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any copayment for the vaccine (including administration).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. If you're retroactively enrolled in our plan

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

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

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

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

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. Go to Chapter 5, Section 2.4 to learn about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

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

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

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

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

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

- For example, the drug may not be on our plan's Drug List, or it could have a requirement or restriction you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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

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

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

To make sure you're giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment. You don't have to use the form, but it 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.
- Download a copy of the form from our website (**kp.org**) or call Member Services at 1-877-221-8221 (TTY users call 711) and ask for the form. Mail the completed form to our Claims Department address listed below.
- If you are unable to get the form, you can file your request for payment by sending us the following information to our Claims Department address listed below:
- A statement with the following information:
  - Your name (member/patient name) and medical/health record number.
  - The date you received the services.
  - Where you received the services.
  - Who provided the services.
  - Why you think we should pay for the services.
  - Your signature and date signed. (If you want someone other than yourself to make the request, we will also need a completed "Appointment of Representative" form, which is available at **kp.org**.)
- A copy of the bill, your medical record(s) for these services and your receipt if you paid for the services.

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

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

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

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

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

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

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

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

Chapter 8 — Your rights and responsibilities

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

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in large font, braille, audio file, or data CD at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at 1-877-221-8221 (TTY users call 711).

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

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Member Services at 1-877-221-8221 (TTY users call 711). You can also file a complaint with Medicare by calling **1-800-MEDICARE (1-800-633-4227)** or directly with the Office for Civil Rights **1-800-368-1019** or TTY **1-800-537-7697**.

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

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

You have the right to get appointments and covered services from our plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or

refilled at any of our network pharmacies without long delays.

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

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

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

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
  - You have rights related to your information and controlling how your health information is used. We give you a written notice, called a **Notice of Privacy Practices**, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

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

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

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

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

If you have questions or concerns about the privacy of your personal health information, call Member Services at 1-877-221-8221 (TTY users call 711).

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

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

If you want any of the following kinds of information, call Member Services at 1-877-221-8221 (TTY users call 711):

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

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

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

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

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

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

Sometimes people become unable to make health care decisions for themselves due to accidents

or serious illness. You have the right to say what you want to happen if you're in this situation. This means, if you want to, you can:

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

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

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Member Services at 1-877-221-8221 (TTY users call 711) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

If your instructions aren't followed

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

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

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

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

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

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

- **Call Member Services at 1-877-221-8221 (TTY users call 711)**
- **Call your local SHIP** at 1-800-722-4134 (Oregon's SHIP) (TTY users call 711), or 1-800-562-6900 (Washington's SHIP) (TTY users call 1-360-586-0241)
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 – How to get more information about your rights

Get more information about your rights from these places:

- **Call our plan's Member Services at 1-877-221-8221 (TTY users call 711)**
- **Call your local SHIP** at 1-800-722-4134 (Oregon's SHIP) (TTY users call 711), or 1-800-562-6900 (Washington's SHIP) (TTY users call 1-360-586-0241)
- **Contact Medicare**
  - Visit **www.Medicare.gov** to read the publication Medicare Rights & Protections (available at: **www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf)**
  - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.9 – Information about new technology assessments

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

Section 1.10 – You can make suggestions about rights and responsibilities

As a member of our plan, you have the right to make recommendations about the rights and responsibilities included in this chapter. Please call Member Services at 1-877-221-8221 (TTY users call 711) with any suggestions.

Section 2 — Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Member Services at 1-877-221-8221 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this **Evidence of Coverage** to learn what's covered and the rules you need to follow to get covered services.
  - Chapter 3 and Chapter 4 give details about medical services.
  - Chapter 5 and Chapter 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan**. Show our plan membership card whenever you get medical care or Part D drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
  - Make sure you understand your health problems and participate in developing mutually agreed upon treatment goals with your providers whenever possible.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - You must pay your plan premiums.
  - You must continue to pay a premium for your Medicare Part B to stay a member of our plan.
  - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
  - If you're required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
  - If you're required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to stay a member of our plan.
- **If you move *within* your plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* your plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

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

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

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

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

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

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

Other dispute resolution options

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

Section 1.1 – Legal terms

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

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

Section 2 — Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at 1-877-221-8221 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help you are:

State Health Insurance Assistance Program (SHIP)

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

The services of SHIP counselors are free. SHIP contact information is available in Chapter 2,

Section 3.

Medicare

You can also contact Medicare for help.

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

Section 3 — Which process to use for your problem

Is your problem or concern about your benefits or coverage?

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

- **Yes.**
  - Go to **Section 4, A guide to coverage decisions and appeals**
- **No.**
  - Go to **Section 10, How to make a complaint about quality of care, waiting times, customer service or other concerns.**

COVERAGE DECISIONS AND APPEALS

Section 4 — A guide to coverage decisions and appeals

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

Asking for coverage decisions before you get services

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

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is

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

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

Making an appeal

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

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

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

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

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

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

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

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

- **Call us at Member Services at 1-877-221-8221 (TTY users call 711)**
- **Get free help** from your **State Health Insurance Assistance Program**

- **Your doctor can make a request for you**. If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at 1-877-221-8221 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **kp.org**.)
  - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
  - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call Member Services at 1-877-221-8221 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at **www.cms.gov/Medicare/CMS-Forms/CMS Forms/downloads/cms1696.pdf** or on our website at **kp.org**). This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
  - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 – Rules and deadlines for different situations

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

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

If you're not sure which information applies to you, call Member Services at 1-877-221-8221

(TTY users call 711). You can also get help or information from your SHIP.

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

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

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

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

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

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

Section 5.2 – How to ask for a coverage decision

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

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

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

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

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

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

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

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

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

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

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

- **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 10 for information on complaints.)

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

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a *fast complaint*. (Go to Section 10 for information on complaints.) We'll call you as soon as we make the decision.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no.

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

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

Section 5.3 – How to make a Level 1 appeal

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

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

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

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

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

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.

- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We're allowed to charge a fee for copying and sending this information to you.

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
  - If you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
  - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we receive your appeal. We'll give you our decision sooner if your health condition requires us to.
  - If you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
  - If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 10 of this chapter for information on complaints.)
  - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage **within 30 calendar days** if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 – The Level 2 appeal process

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

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

Step 1: The independent review organization reviews your appeal.

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

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

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

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

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

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

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

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

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 explains the Level 3, 4, and 5 appeals processes.

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

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

Asking for reimbursement is asking for a coverage decision from us

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

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

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

To make this appeal, follow the process for appeals in Section 5.3. For appeals concerning reimbursement, **note:**

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

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

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

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs, go to Chapters 5 and 6. **This section is about your Part D drugs only**. To keep things simple, we generally say drug in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term Drug List instead of *List of Covered Drugs* or **2026 Comprehensive Formulary**.

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

Part D coverage decisions and appeals

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

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

- Asking to cover a Part D drug that's not on our **2026 Comprehensive Formulary. Ask for an exception. Section 6.2.**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 6.2.**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2.**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4.**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4.**

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

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

Section 6.2 – Asking for an exception

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

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

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to drugs in Tier 5 for specialty tier drugs or Tier 2 for generic drugs. You can't ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost sharing amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier**. Every drug on our Drug List is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you pay as your share of the cost of the drug.
   - If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).

- If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
- If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
- If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You can't ask us to change the cost-sharing tier for any drug in Tier 5 (specialty-tier drugs).
- If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

Section 6.3 – Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

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

We can say yes or no to your request

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

Section 6.4 – How to ask for a coverage decision, including an exception

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

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

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

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

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

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

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form*, which is available on our website (**kp.org**). Chapter 2 has contact information. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

You, your doctor (or other prescriber), or your representative can do this. You can also have a lawyer act on your behalf. Section 4 tells how you can give written permission to someone else to act as your representative.

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

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

Deadlines for a fast coverage decision

- We must generally give you our answer within 24 hours after we get your request.
  - For exceptions, we'll give you our answer **within 24 hours** after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.

- If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

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

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

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

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

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

Section 6.5 – How to make a Level 1 appeal

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

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

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

- If you're appealing a decision we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4 of this chapter.

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

- **For standard appeals, submit a written request.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at (1-877-221-8221**). Chapter 2 has contact information.
- **We must accept any written request**, including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website (kp.org). Include your name, contact information, and information about your claim to help us process your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We're allowed to charge a fee for copying and sending this information to you.

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal.** We'll give you our answer sooner if your health requires us to.
  - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

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

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
  - If we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

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

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

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

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

Section 6.6 – How to make a Level 2 appeal

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

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

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

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.
  - You must make your appeal request within 65 calendar days from the date on the written notice.

- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE.
- We'll send the information about your appeal to the independent review organization. This information is called your **case file. You have the right to ask us for a copy of your case file**. We're allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

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

Deadlines for fast appeal

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

Deadlines for standard appeal

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

Step 3: The independent review organization gives you its answer.

For fast appeals:

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

For standard appeals:

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

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

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

you a letter that:

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

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go on to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7 — How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

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

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

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

Section 7.1 – During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called **An Important Message from Medicare about Your Rights.** Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at 1-877-221-8221 (TTY users call 711) or **1-800-MEDICARE (1-800-633-4227)** (TTY users call **1-877-486-2048**).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.

- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about the quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we'll cover your hospital care for a longer time.

2**. You'll be asked to sign the written notice to show that you got it and understand your rights.**

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows only that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice doesn't mean you're agreeing on a discharge date.

3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Member Services at 1-877-221-8221 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at www.cms.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 7.2 – How to make a Level 1 appeal to change your hospital discharge date

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

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-877-221-8221 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

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

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

How can you contact this organization?

- The written notice you got **(An Important Message from Medicare about Your Rights)** tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
  - **If you meet this deadline,** you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
  - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge, the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge.** This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at 1-877-221-8221 (TTY users call 711) or **1-800-MEDICARE (1-800-633-4227)**. (TTY users call **1-877-486-2048**.) Or you can get a sample notice online at **www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.**

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

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

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

What happens if the answer is yes?

- If the independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**

- You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

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

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

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

Section 7.3 – How to make a Level 2 appeal to change your hospital discharge date

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

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

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

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

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

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

If the independent review organization says yes:

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

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called upholding the decision.

- The notice you get will tell you in writing what you can do if you want to continue with the review process.

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8 — How to ask us to keep covering certain medical services if you think your coverage is ending too soon

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

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

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

Section 8.1 – We'll tell you in advance when your coverage will be ending

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

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:

- The date when we'll stop covering the care for you.
- How to ask for a fast track appeal to ask us to keep covering your care for a longer period of time.

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

Section 8.2 – How to make a Level 1 appeal to have our plan cover your care for a longer time

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-877-221-8221 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

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

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

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

How can you contact this organization?

- The written notice you got (**Notice of Medicare Non-Coverage**) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the **Notice of Medicare Non-Coverage.**
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the **Notice of Medicare Non-coverage**. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

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

Legal Term	**Detailed Explanation of Non-Coverage.** Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.

- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

- If reviewers say *no* to your Level 1 appeal - and you choose to continue getting care after your coverage for the care has ended - then you can make a Level 2 appeal.

Section 8.3 – How to make a Level 2 appeal to have our plan cover your care for a longer time

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

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

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

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

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

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on

your appeal and tell you their decision.

What happens if the independent review organization says yes?

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

What happens if the independent review organization says no?

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

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

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator.
- Section 9 tells more about Levels 3, 4, and 5 of the appeals process.

Section 9 — Taking your appeal to Levels 3, 4, and 5

Section 9.1 – Appeal Levels 3, 4, and 5 for Medical Service Requests

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

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

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

Level 3 appeal

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

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over**. Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.

- If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
- If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.

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

Level 4 appeal

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

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

Level 5 appeal

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

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

Section 9.2 – Appeal Levels 3, 4, and 5 for Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to

additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

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

Level 3 appeal

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

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

Level 4 appeal

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

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

Level 5 appeal

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

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

MAKING COMPLAINTS

Section 10 — How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 – What kinds of problems are handled by the complaint process?

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan? o Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all about the *timeliness* of our actions related to coverage decisions and appeals)	• If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: o You asked us for a *fast coverage decision* or a *fast appeal*, and we said no; you can make a complaint. o You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint.

Complaint	Example
	o You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. o You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 10.2 – How to make a complaint

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

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

- **Calling Member Services at 1-877-221-8221 (TTY users call 711) is usually the first step**. If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing. We'll also respond in writing when you make a complaint by phone if you request a written response or your complaint is related to quality of care.
- **If you have a complaint, we 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.
  - o 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.
  - o You can file a fast grievance about our decision not to expedite a coverage decision or appeal for medical care or items, or if we extend the time we need to make a decision about a coverage decision or appeal for medical care or items. We must respond to your fast grievance **within 24 hours**.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

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

Section 10.3 – You can also make complaints about quality of care to the Quality Improvement Organization

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

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 10.4 – You can also tell Medicare about your complaint

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

Chapter 10 — Ending membership in our plan

Section 1 — Ending your membership in our plan

Ending your membership in our plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you want to leave. Section 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care and prescription drugs, and you'll continue to pay your cost share until your membership ends.

Section 2 — When can you end your membership in our plan?

You may terminate (disenroll from) your Senior Advantage membership at any time. However, before you request disenrollment, please check with your group to determine if you are able to continue your group membership. If you request disenrollment during your group's open enrollment, your disenrollment effective date is determined by the date your written request is received by us and the date your group coverage ends. The effective date will not be earlier than the first day of the following month after we receive your written request, and no later than three months after we receive your request.

If you request disenrollment at a time other than your group's open enrollment, your disenrollment effective date will be the first day of the month following our receipt of your written, signed, and dated disenrollment request.

Other Medicare health plans

If you want to enroll in another Medicare Advantage health plan or a Medicare prescription drug plan, you should first confirm with the other plan and your group that you are able to enroll in their plan. Your new plan will tell you the date when your membership in that plan begins and your Senior Advantage membership will end on that same day (your disenrollment date).

The Centers for Medicare & Medicaid Services will let us know if you enroll in another Medicare Advantage health plan, so you will not need to send us a disenrollment request. If you enroll in some other type of Medicare Supplemental coverage, a signed disenrollment request must be received prior to the date of your new coverage, requesting your specific disenrollment date.

Original Medicare

If you request disenrollment from Senior Advantage and you do not enroll in another Medicare health plan, you will automatically be enrolled in Original Medicare when your Senior Advantage membership terminates (your disenrollment date). On your disenrollment date, you can start using your red, white, and blue Medicare card to get services under Original Medicare. You will not get anything in writing that tells you that you have Original Medicare after you

disenroll. If you choose Original Medicare and you want to continue to get Medicare Part D prescription drug coverage, you will need to enroll in a prescription drug plan.

Section 2.1 – Get more information about when you can end your membership

If you have questions about ending your group membership, you can:

- Contact your group's benefits administrator.
- **Call Member Services at 1-877-221-8221 (TTY users call 711)**.
- Find the information in the **Medicare & You 2026** handbook.
- Call Medicare at **1-800-MEDICARE (1-800-633-4227).** TTY users call **1-877-486-2048**.

Section 3 — How to end your membership in our plan

You may request disenrollment by:

- Requesting disenrollment with your group's benefits administrator by submitting a signed disenrollment request prior to the date you would like to be terminated. You should always consult them before taking any action because it can affect your eligibility for group benefits.
- Calling **Medicare** 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 us a written notice to the following address:

  Kaiser Permanente
  Medicare Department
  P.O. Box 232407
  San Diego, CA 92193-9914

Section 4 — Until your membership ends, you must keep getting your medical items, services, and drugs through our plan

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical services, items, and prescription drugs through our plan.

- **Continue to use our network providers to get medical care.**
- **Continue to use our network pharmacies *or* mail order to get your prescriptions filled.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

Section 5 — We must end our plan membership in certain situations

We must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.

- If you're away from our service area for more than 6 months.
  - If you move or take a long trip, call Member Services at 1-877-221-8221 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you'll lose drug coverage.

If you have questions or want more information on when we can end your membership, call Member Services at 1-877-221-8221 (TTY users call 711).

Section 5.1 – We can't ask you to leave our plan for any health-related reason

We aren't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at **1-800-MEDICARE (1-800-633-4227**). TTY users call **1-877-486-2048**.

Section 5.2 – You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

Section 5.3 – What happens if you are no longer eligible for group coverage

After your group notifies us to terminate your group membership, we will send a termination letter to the subscriber's address of record. The letter will include information about options that may be available to you to remain a Health Plan member.

- If you are no longer eligible for group membership, you can request enrollment in our Senior Advantage Individual Plan if you still meet the eligibility requirements for Senior Advantage. The premiums and coverage under our individual plan will differ from those under this **EOC** and will include Medicare Part D prescription drug coverage.
- You may not be eligible to enroll in our Senior Advantage individual plan if your membership ends for the reasons stated under Section 5. For more information or information about other individual plans, call Member Services. Phone numbers are printed on the back cover of this document.

Chapter 11 — Legal notices

Section 1 — Notice about governing law

The principal law that applies to this **Evidence of Coverage** document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

Section 2 — Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage Plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at **1-800-368-1019** (TTY **1-800-537-7697**) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at **HHS.gov/ocr/index.html**.

If you have a disability and need help with access to care, call us at Member Services at 1-877-221-8221 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Section 3 — Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Kaiser Permanente Senior Advantage, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

Section 4 — Administration of this Evidence of Coverage

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this **Evidence of Coverage**.

Section 5 — Amendment of Agreement

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

Section 6 — Applications and statements

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

Section 7 — Assignment

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

Section 8 — Attorney and advocate fees and expenses

In any dispute between a member and Health Plan, Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses, except as otherwise required by law.

Section 9 — Coordination of benefits

As described in Chapter 1, Section 6, "How other insurance works with our plan," if you have other insurance, you are required to use your other coverage in combination with your coverage as a Senior Advantage plan member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. You will get your covered care as usual from network providers, and the other coverage you have will simply help pay for the care you receive.

If your other coverage is the primary payer, it will often settle its share of payment directly with us, and you will not have to be involved. However, if payment owed to us by a primary payer is sent directly to you, you are required by Medicare law to give this primary payment to us. For more information about primary payments in third party liability situations, see Section 17 in this chapter, and for primary payments in workers' compensation cases, see Section 19 in this chapter.

You must tell us if you have other health care coverage, and let us know whenever there are any changes in your additional coverage.

Section 10 — Employer responsibility

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

Section 11 — Evidence of Coverage binding on members

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

Section 12 — Government agency responsibility

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

Section 13 — Member nonliability

Our contracts with network providers provide that you are not liable for any amounts we owe. However, you are liable for the cost of non-covered services you obtain from network providers or out-of-network providers.

Section 14 — No waiver

Our failure to enforce any provision of this **Evidence of Coverage** will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Section 15 — Notices

Our notices to you will be sent to the most recent address we have. You are responsible for notifying us of any change in your address. If you move, please call Member Services (phone numbers are printed on the back of this document) and Social Security at **1-800-772-1213** (TTY **1-800-325-0778**) as soon as possible to report your address change.

Section 16 — Overpayment recovery

We may recover any overpayment we make for services from anyone who receives such an overpayment or from any person or organization obligated to pay for the services.

Section 17 — Third party liability

As stated in Chapter 1, Section 6, third parties who cause you injury or illness (and/or their insurance companies) usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue these primary payments. If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered services, you must ensure we receive reimbursement for those services.

Note: This "Third party liability" section does not affect your obligation to pay cost-sharing for these services.

To the extent permitted or required by law, we shall be subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain against a third party that results in any settlement proceeds or judgment, from other types of coverage that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, workers' compensation, personal injury, medical payments and all other first party types. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether you are made whole and regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred. We are not required to pay attorney fees or costs to any attorney hired by you to pursue your damages claim. If you reimburse us without the need for legal action, we will allow a procurement cost discount. If we have to pursue legal action to enforce its interest, there will be no procurement discount.

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

Equian, LLC
Attn: Subrogation Operations
P.O. Box 36380
Louisville, KY 40233
Fax: 502-214-1291

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

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

Section 18 — U.S. Department of Veterans Affairs

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

Section 19 — Workers' compensation or employer's liability benefits

As stated in Chapter 1, Section 6, workers' compensation usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue primary payments under workers' compensation or employer's liability law. You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered services from the following sources:

- From any source providing a Financial Benefit or from whom a Financial Benefit is due.
- From you, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

Section 20 — Surrogacy

In situations where a member receives monetary compensation to act as a surrogate, our plan will seek reimbursement of all Plan Charges for covered services the member receives that are associated with conception, pregnancy and/or delivery of the child. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Chapter 12 — Definitions

Allowance – A specified credit amount that you can use toward the cost of an item or service. If the cost of the item(s) or service(s) you select exceeds the allowance, you will pay the amount in excess of the allowance, which does not apply to the maximum out-of-pocket amount.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing our plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measure your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't gotten any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars (go to "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (go to "**Interchangeable Biosimilar**").

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent **$2,100** for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs. You may have cost sharing for excluded drugs that are covered under our enhanced benefit.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) of Plan Charges as your share of the cost for services or prescription drugs after you pay any deductibles.

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Formulary (Formulary or Drug List) – A list of prescription drugs covered by our plan.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Coordination of Benefits (COB) – Coordination of Benefits is a provision used to establish the order in which claims are paid when you have other insurance. If you have Medicare and other health insurance or coverage, each type of coverage is called a payer. When there is more than one payer, there are coordination of benefits rules that decide which one pays first. The primary payer pays what it owes on your bills first, and then sends the rest to the secondary payer to pay. If payment owed to us is sent directly to you, you're required under Medicare law to give the payment to us. In some cases, there may also be a third payer. See Chapter 1, Section 6, and Chapter 11, Section 9, for more information.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are gotten. Cost sharing includes any combination of the following 3 types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed copayment amount that a plan requires when a specific service or drug is gotten; or (3) any coinsurance amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is gotten. **Note:** In some cases, you may not pay all applicable cost-sharing at the time you receive the services, and we will send you a bill later for the cost-sharing. For example, if you receive non-preventive care during a scheduled preventive care visit, we may bill you later for the cost-sharing applicable to the non-preventive care. For items ordered in advance, you pay the cost-sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the cost-sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by

our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all the prescription drugs covered by our plan.

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in our plan is 30 days, then your daily cost-sharing rate is $1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Dependent – A member who meets the eligibility requirements as a dependent (for dependent eligibility requirements, see Chapter 1, Section 2).

Disenroll or Disenrollment – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the person's eligibility.

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Emergency Medical Condition – A medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction (a formulary exception).

Excluded Drug – A drug that's 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.

Generic Drug – A prescription drug that's approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Group – The entity with which we have entered into the **Agreement** that includes this **Evidence of Coverage**.

Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Medical Benefits Chart found at the front of this **EOC**. We cover home health care in accord with Medicare guidelines. Home health care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you're also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people won't pay a higher premium.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

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

Inpatient Hospital Care – Health care that you get during an inpatient stay in an acute care general hospital.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

Kaiser Foundation Health Plan (Health Plan) – Kaiser Foundation Health Plan of the Northwest is a nonprofit corporation and a Medicare Advantage organization. This **Evidence of Coverage** sometimes refers to Health Plan as "we" or "us."

Kaiser Foundation Hospital – A network hospital owned and operated by Kaiser Foundation Hospitals.

Kaiser Permanente – Health Plan, Medical Group, and Kaiser Foundation Hospitals.

Kaiser Permanente Region (Region) – A Kaiser Foundation Health Plan organization that conducts a direct-service health care program. When you're outside our service area, you can get medically necessary health care and ongoing care for chronic conditions from designated providers in another Kaiser Permanente Region's service area. For more information, please refer to Chapter 3, Section 2.4.

Long-Term Care Hospital – A Medicare-certified acute-care hospital that typically provides Medicare covered services such as comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. They aren't long-term care facilities such as convalescent or assisted living facilities.

Low-Income Subsidy (LIS) – Go to Extra Help.

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

Maximum Fair Price – The price Medicare negotiated for a selected drug.

Maximum Out-of-Pocket Amount – The most that you pay out of pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for any contributions to your group's monthly premium, your Medicare Part A and Part B premiums, and prescription drugs don't count toward the maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medical Care or Services – Health care services or items. Some examples of health care items include durable medical equipment, eyeglasses, and drugs covered by Medicare Part A or Part B, but not drugs covered under Medicare Part D.

Medical Group – It is the network of plan providers that our plan contracts with to provide covered services to you. The name of our medical group is Northwest Permanente, P.C., a for-profit professional corporation.

Medically Accepted Indication – A use of a drug that is either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be (i) an HMO, (ii) a PPO, (iii) a Private

Fee-for-Service (PFFS) plan, or (iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage.**

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Physician – Any licensed physician who is an employee of Medical Group, or any licensed physician who contracts to provide services to our members (but not including physicians who contract only to provide referral services).

Network Provider – **Provider** is the general term for doctors, other health care professionals (including, but not limited to, physician assistants, nurse practitioners, and nurses), hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to

members of our plan. Network providers are also called **plan providers**.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

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

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs gotten is also referred to as the member's out-of-pocket cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

Part C – Go to **Medicare Advantage (MA) Plan.**

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that's expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan.

Plan – Kaiser Permanente Senior Advantage.

Plan Charges – Plan Charges means the following:

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

Post-Stabilization Care – Medically necessary services related to your emergency medical condition that you get after your treating physician determines that this condition is clinically stable. You're considered clinically stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards that you're safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they're received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services gotten from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services and/or certain drugs based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart found at the front of this **EOC**. Covered drugs that need prior authorization are

marked in the formulary and our criteria are posted on our website.

Prosthetics and Orthotics – Medical devices including, but not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy and urological supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

"Real-Time Benefit Tool" – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. We must disenroll you if you permanently move out of our plan's service area.

Services – Health care services, supplies or items.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

Specialty-Tier Drugs – Very high-cost drugs approved by the FDA that are on our formulary.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we'll cover the drug your physician may have initially prescribed.

Subscriber – A member who is eligible for membership on his or her own behalf and not by virtue of dependent status (for subscriber eligibility requirements, see Chapter 1, Section 2).

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention

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

KAISER PERMANENTE®

Kaiser Permanente Senior Advantage Member Services

	Member Services – Contact Information
Call	**1-877-221-8221** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services at 1-877-221-8221 (TTY users call 711) also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
Write	Kaiser Permanente Member Services 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099
Website	**kp.org**

State Health Insurance Assistance Program

A State Health Insurance Assistance Program (SHIP) is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. Please see Chapter 2, Section 3, for SHIP contact information.

Nondiscrimination Notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, braille, and accessible electronic formats
- Provides no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Member Services at **1-800-813-2000** (TTY: **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at:

Member Relations Department
Attention: Kaiser Civil Rights Coordinator
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: **1-855-347-7239**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: **1-800-368-1019**
TDD: **1-800-537-7697**

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

For Washington Members:
You can also file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal, available at **https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status**, or by phone at **1-800-562-6900**, or **360-586-0241** (TDD). Complaint forms are available at **https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx**.

This notice is available at https://healthy.kaiserpermanente.org/oregon-washington/language-assistance/nondiscrimination-notice

Help in Your Language

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call 1-800-813-2000 (TTY: 711).

አማርኛ (Amharic) ትኩረት: አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-813-2000** ይደውሉ (TTY: **711**)።

العربية (Arabic)تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-800-813-2000** (TTY: **711**).

中文 **(Chinese)** 注意事項：如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電**1-800-813-2000**（**TTY**：**711**）。

فارسی (Farsi)توجه: اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با**1-800-813-2000** تماس بگیرید ( )TTYتلفن متنی): **711**).

Français (French) ATTENTION : si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-813-2000** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-813-2000** an (TTY: **711**).

日本語（**Japanese**）注意：日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-800-813-2000**までお電話ください（TTY：**711**）。

ខ្មែរ (Khmer) យកចិត្តទុកដាក់៖ បើអ្នកនិយាយខ្មែរ សេវាជំនួយភាសា រួមទាំងជំនួយនិងសេវាសម្រួលដោយឥតគិតថ្លៃ មានចំពោះអ្នក។ ហៅ **1-800-813-2000** (TTY: **711**).

한국어 (**Korean**) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-813-2000**로 전화해 주세요(TTY: **711**).

ລາວ (Laotian) ເອົ າໃຈໃส ่: ຖ ้ າທ ่ ານເວ ົ ้ າພ ูดภาวาอ, ภาบบ ่ ໍ ລ ิ ภูบ ุ ร ่ อยเຫ ู ิ ย ด ้ ານພ ูาสา ฉอมฟ ู ย ่ ปะภอบ ุเดอะ ภาบบ ่ ว ภาบช ุ อยเຫ ู ย ภ เหมาะส ่ ม จะม ใช ้ ท ้ านโดยบ ่ เสยค ่ า. โท **1-800-813-2000** (TTY: **711**).

Afaan Oromoo (Oromo) XIYYEEFFANNOO: Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. **1-800-813-2000** irratti bilbilaa (TTY:- **711**)

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਜਿਨ੍ਹਾਂ ਵਿੱਚ ਯੋਗ ਸਹਾਇਕ ਸਹਾਇਤਾਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਸ਼ਾਮਲ ਹਨ। ਕਾਲ ਕਰੋ **1-800-813-2000** (TTY:- **711**).

Română (Romanian) ATENȚIE: Dacă vorbiți română, vă sunt disponibile gratuit servicii de asistență lingvistică, inclusiv ajutoare și servicii auxiliare adecvate. Sunați la **1-800-813-2000** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные

услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-813-2000** (TTY: **711**).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-813-2000** (TTY: **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-813-2000** (TTY: **711**).

ไทย (Thai) โปรดทราบ: หากท่านพูดภาษาไทย ท่านสามารถขอรับบริการช่วยเหลือด้านภาษา รวมทั้งเครื่องช่วยเหลือและบริการเสริมที่เหมาะสมได้ฟรี โทร **1-800-813-2000** (TTY: **711**).

Українська (Ukrainian) УВАГА! Якщо ви володієте українською мовою, вам доступні безкоштовні послуги з мовної допомоги, включно із відповідною додатковою допомогою та послугами. Зателефонуйте за номером **1-800-813-2000** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-813-2000** (TTY: **711**).

Acupuncture Services Rider
Kaiser Permanente Senior Advantage (HMO)

This rider is part of the **Kaiser Permanente Senior Advantage (HMO) Evidence of Coverage (EOC)** to which it is attached. All provisions of this rider become part of the **EOC** "Chapter 4: Medical Benefits Chart (what's covered and what you pay)." This entire benefit rider is therefore subject to all the terms and provisions of the **EOC**.

We cover the services described in this "Acupuncture Services Rider" when services are received from a network provider and provided as outpatient services in the network provider's office.

To locate a network provider, visit **www.herayahealth.com**. Heraya Health is a network provider we contract with to provide alternative care services. If you need assistance searching for a network provider, or to verify the current participation status of a provider, or if you do not have access to the online directory, please contact Member Services.

If a benefit maximum is listed in the Medical Benefits Chart "Alternative care therapies (self-referred)" section, you are responsible for paying the full amount for services after you reach the benefit maximum.

Services are subject to any visit limits and applicable cost-sharing listed in the Medical Benefits Chart "Alternative care therapies (self-referred)" section.

Acupuncture services

Acupuncturists influence the health of the body by the insertion of very fine needles. Acupuncture treatment is primarily used to relieve pain, reduce inflammation, and promote healing. Covered services include:

- Evaluation and management.
- Acupuncture.
- Electro acupuncture.

Acupuncture services rider exclusions

- Dermal friction technique.
- East Asian massage and tui na.
- Laserpuncture.
- Nambudripad allergy elimination technique (NAET).
- Point injection therapy.
- Qi gong.
- Services designed to maintain optimal health in the absence of symptoms.
- Sonopuncture.

Chiropractic Services Rider
Kaiser Permanente Senior Advantage (HMO)

This rider is part of the **Kaiser Permanente Senior Advantage (HMO) Evidence of Coverage (EOC)** to which it is attached. All provisions of this rider become part of the **EOC** "Chapter 4: Medical Benefits Chart (what's covered and what you pay)." This entire benefit rider is therefore subject to all the terms and provisions of the **EOC**.

We cover the services described in this "Chiropractic Services Rider" when services are received from a network provider and provided as outpatient services in the network provider's office.

To locate a network provider, visit **www.herayahealth.com**. Heraya Health is a network provider we contract with to provide alternative care services. If you need assistance searching for a network provider, or to verify the current participation status of a provider, or if you do not have access to the online directory, please contact Member Services.

If a benefit maximum is listed in the Medical Benefits Chart "Alternative care therapies (self-referred)" section, you are responsible for paying the full amount for services after you reach the benefit maximum.

Services are subject to any visit limits and applicable cost-sharing listed in the Medical Benefits Chart "Alternative care therapies (self-referred)" section.

Chiropractic services

Chiropractic and manual manipulation of the spine, joints, or soft tissue focuses on reducing pain and improving the function and structure of the body. It is a system of therapy that involves non-invasive care promoting science-based approaches to a variety of ailments. Covered services include:

- Evaluation and management.
- Musculoskeletal treatments.
- Physical therapy modalities such as hot and cold packs.

When prescribed by a network provider, X-ray procedures are covered as described in the Medical Benefits Chart "Outpatient diagnostic tests and therapeutic services and supplies" section.

Chiropractic services rider exclusions

- Dermal friction technique.
- East Asian massage and tui na.
- Nambudripad allergy elimination technique (NAET).
- Qi gong.
- Services designed to maintain optimal health in the absence of symptoms.
- Sonopuncture.

Massage Therapy Rider
Kaiser Permanente Senior Advantage (HMO)

This rider is part of the **Kaiser Permanente Senior Advantage (HMO) Evidence of Coverage (EOC)** to which it is attached. All provisions of this rider become part of the **EOC** "Chapter 4: Medical Benefits Chart (what's covered and what you pay)." This entire benefit rider is therefore subject to all the terms and provisions of the **EOC**.

We cover the services described in this "Massage Therapy Rider" when services are received from a network provider and provided as outpatient services in the network provider's office.

To locate a network provider, visit **www.herayahealth.com**. Heraya Health is a network provider we contract with to provide alternative care services. If you need assistance searching for a network provider, or to verify the current participation status of a provider, or if you do not have access to the online directory, please contact Member Services.

If a benefit maximum is listed in the Medical Benefits Chart "Alternative care therapies (self-referred)" section, you are responsible for paying the full amount for services after you reach the benefit maximum.

Services are subject to any visit limits and applicable cost-sharing listed in the Medical Benefits Chart "Alternative care therapies (self-referred)" section.

Massage therapy services

Therapeutic massage involves the manipulation of soft tissue structures of the body to help alleviate pain, muscle discomfort, and stress by helping to promote health and wellness. Covered services include therapeutic massage procedures.

Massage therapy services rider exclusions

- Dermal friction technique.
- East Asian massage and tui na.
- Qi gong.
- Services designed to maintain optimal health in the absence of symptoms.

Naturopathic Medicine Rider
Kaiser Permanente Senior Advantage (HMO)

This rider is part of the **Kaiser Permanente Senior Advantage (HMO) Evidence of Coverage (EOC)** to which it is attached. All provisions of this rider become part of the **EOC** "Chapter 4: Medical Benefits Chart (what's covered and what you pay)." This entire benefit rider is therefore subject to all the terms and provisions of the **EOC**.

We cover the services described in this "Naturopathic Medicine Rider" when services are received from a network provider and provided as outpatient services in the network provider's office.

To locate a network provider, visit **www.herayahealth.com**. Heraya Health is a network provider we contract with to provide alternative care services. If you need assistance searching for a network provider, or to verify the current participation status of a provider, or if you do not have access to the online directory, please contact Member Services.

If a benefit maximum is listed in the Medical Benefits Chart "Alternative care therapies (self-referred)" section, you are responsible for paying the full amount for services after you reach the benefit maximum.

Services are subject to any visit limits and applicable cost-sharing listed in the Medical Benefits Chart "Alternative care therapies (self-referred)" section.

Naturopathic medicine services

Naturopathic medicine is a natural approach to health and healing which emphasizes a holistic approach to the diagnosis, treatment, and prevention of illness. Naturopathic physicians diagnose and treat patients by using natural modalities such as clinical nutrition, herbal medicine, and homeopathy. Covered services include:

- Evaluation and management.
- Health condition related treatments.
- Physical therapy modalities such as hot and cold packs.

When prescribed by a network provider, certain laboratory procedures are covered as described in the Medical Benefits Chart "Outpatient diagnostic tests and therapeutic services and supplies" section.

Prescription Eyewear Rider
Kaiser Permanente Senior Advantage (HMO)

This rider is part of the **Kaiser Permanente Senior Advantage (HMO) Evidence of Coverage (EOC)** to which it is attached. All provisions of this rider become part of the **EOC** "Chapter 4: Medical Benefits Chart (what's covered and what you pay)." This entire benefit rider is therefore subject to all the terms and provisions of the **EOC.**

We cover the services listed in this rider at network optical centers when prescribed by a network provider or an out-of-network provider.

Note: This "Prescription Eyewear Rider" benefit is effective in the current contract year and may not be available next year.

Eyeglasses and contact lenses

We provide an allowance toward the price of prescription eyeglass lenses and a frame, or conventional or disposable prescription contact lenses, including medically necessary contact lenses. The allowance and your cost-sharing, if any, are listed in the Medical Benefits Chart "Vision care, Prescription eyewear" section. If the covered eyewear item you purchase costs more than the allowance for that item, you pay the difference. We will not provide the allowance if we have previously covered an eyewear item under this rider within the same allowance period.

The date we cover any of these prescription eyewear items is the date on which you order the item. If you order the item while you are covered under this **EOC,** and if we would otherwise cover the item, we will cover the prescription eyewear item even if you do not receive it until after you are no longer covered under this **EOC.**

Medically necessary contact lenses

Contact lenses may be determined to be medically necessary and appropriate in the treatment of the following conditions:

- Keratoconus.
- Pathological myopia.
- Aphakia.
- Anisometropia.
- Aniseikonia.
- Aniridia.
- Corneal disorders.
- Post-traumatic disorders.
- Irregular astigmatism.

Prescription eyewear rider exclusions

- Low vision aids.

- Non-prescription products (other than eyeglass frames), such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.
- Non-prescription sunglasses.
- Optometric vision therapy and orthoptics (eye exercises).
- Plano contact lenses or glasses (non-prescription).
- Professional services for evaluation, fitting and follow-up care for contact lenses, except that this exclusion does not apply to medically necessary contact lenses.
- Replacement of lost, broken, or damaged lenses or frames.