Kaiser Permanente PEBB Retiree Employer Group Medicare Advantage 2023 Contract Year

Evidence of Coverage

Your Medicare Health Benefits and Services as a Member of Kaiser Permanente Medicare Advantage PEBB Retiree Employer Group Plan (HMO)

This document gives you the details about your Medicare health care coverage your PEBB Retiree Employer Eroup Medicare Advantage 2023 contract year plan. This is an important legal document. Please keep it in a safe place.

For questions about this document, please contact Member Services at **1-888-901-4600**. (TTY users should call **711**.) Hours are 8 a.m. to 8 p.m., 7 days a week.

This plan, Kaiser Permanente Medicare Advantage PEBB Retiree Employer Group Plan, is offered by Kaiser Foundation Health Plan of Washington (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 Medicare Advantage PEBB Retiree Employer Group Plan.

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

Benefits, premiums, deductibles, and/or copayments/coinsurance may change annually when your employer group contract renews. The provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

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

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

2023 Evidence of Coverage

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Chapter 1 — Getting started as a member

Section 1 — Introduction

Section 1.1 – You are enrolled in Kaiser Permanente Medicare Advantage PEBB Retiree Employer Group Plan, which is a Medicare HMO plan

You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, Kaiser Permanente Medicare Advantage PEBB Retiree Employer Group Plan.

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

Kaiser Permanente Medicare Advantage PEBB Retiree Employer Group Plan is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company. Kaiser Permanente Medicare Advantage PEBBG Retiree Employer Group Plan does not include Medicare Part D prescription drug coverage.

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

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

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

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

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

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

Section 1.3 – Legal information about the Evidence of Coverage

This **Evidence of Coverage** is part of our contract with you about how the PEBB Retiree Employer Group Plan covers your care. Other parts of this contract include your enrollment form and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for the months in which you are enrolled in Kaiser Permanente Medicare Advantage's 2023 PEBB Retiree Employer Group Plan.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of our plan after December 31, 2023. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2023. Changes

made to PEBB Retiree Employer Group Plan after December 31st of each year will not impact our employer group members until their group renews.

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

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

Section 2.1 – Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B.
- You live in our geographic service area (Section 2.2 below describes our service area). If you have been a member of our plan continuously since before January 1999 and you were living outside of our service area before January 1999, you are still eligible as long as you have not moved since before January 1999. Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- You are a United States citizen or are lawfully present in the United States.
- You lock in your Medicare with Kaiser Permanente.
- You remain covered under your employer/union sponsor's retiree health coverage.
- To find out if you have continued coverage on this plan as a Surviving Spouse, contact your employer group plan administrator for more information.

Section 2.2 – Medical plan eligibility and enrollment

In these sections, the term "retiree" or "retiring employee" includes an elected or full-time appointed official of the legislative and executive branch of state government eligible to continue enrollment in Public Employees Benefits Board (PEBB) retiree insurance coverage. The term "retiree" or "retiring school employee" includes a retiring non-represented employee of an educational service district (ESD) or retiring school employee from a School Employees Benefits Board (SEBB) organization. Additionally, "health plan" is used to refer to a plan offering medical or dental, or both, developed by PEBB and provided by a contracted vendor or self-insured plans administered by the Health Care Authority (HCA).

Eligibility for subscribers and dependents

Retiree eligibility
The PEBB Program determines if a retiring employee or retiring school employee is eligible to enroll in PEBB retiree insurance coverage upon receipt of a **PEBB Retiree Election Form (form A)**. If the retiring employee or retiring school employee does not have substantive eligibility or does not meet the procedural requirements for enrollment in PEBB retiree insurance coverage, the PEBB Program will notify them of their right to appeal eligibility decisions. Information about appeals can be found later in this section under "Appeal rights."

Survivor eligibility
The PEBB Program determines whether a dependent is eligible to enroll or continue enrollment in PEBB retiree insurance coverage as a survivor upon receipt of a **PEBB Retiree Election Form (form A)**. If the survivor does not meet the eligibility and procedural requirements for enrollment in PEBB retiree insurance coverage, the PEBB Program will notify them of their right to appeal. Information about appeals can be found later in this section under "Appeal rights."

Dependent eligibility
The following are eligible dependents:

- Legal spouse.
- State-registered domestic partner and substantially equivalent legal unions from jurisdictions as defined in Washington State statute. Individuals in a state-registered domestic partnership are treated the same as a legal spouse except when in conflict with federal law.
- Children, through the last day of the month in which their 26th birthday occurred regardless of marital status, student status, or eligibility for coverage under another plan. It also includes children age 26 or older with a disability as described below in "Children of any age with a developmental or physical disability." Children are defined as the subscriber's:
  - **Children based on establishment of a parent-child relationship**, as described in Washington State statutes, except when parental rights have been terminated.
  - **Children of the subscriber's spouse**, based on the spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to the subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death.
  - **Children for whom the subscriber has assumed a legal obligation** for total or partial support in anticipation of adoption of the child.
  - **Children of the subscriber's state-registered domestic partner**, based on the state-registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber's legal relationship with the state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death.
  - **Children specified in a court order or divorce decree** for whom the subscriber has a legal obligation to provide support or health care coverage.
  - **Extended dependents** in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include foster children unless the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption.

- **Children of any age with a developmental or physical disability** that renders them incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance, provided such condition occurs before the age of 26. The following requirements apply to a dependent child with a disability:
  - The subscriber must provide proof of the disability and dependency within 60 days of the child's attainment of age 26.
  - The subscriber must notify the PEBB Program, in writing when the child is no longer eligible under this subsection.
  - A child with a developmental or physical disability who becomes self-supporting is not eligible as of the last day of the month in which they become capable of self-support.
  - A child with a developmental or physical disability age 26 and older who becomes capable of self-support does not regain eligibility if they later become incapable of self-support.
  - The PEBB Program, with input from the medical plan, will periodically verify the eligibility of a dependent child with a disability beginning at age 26, but no more frequently than annually after the two-year period following the child's 26th birthday. Verification will require renewed proof of disability and dependence from the subscriber.

A retiree, a survivor, or their enrolled dependents are required to enroll in Medicare Part A and Part B if eligible. Any enrollee who is eligible for Medicare must enroll and stay enrolled in Medicare Part A and Part B to enroll in or continue enrollment in a PEBB retiree health plan. A subscriber must provide a copy of their or their dependent's Medicare card or entitlement letter from the Social Security Administration with Medicare Part A and Part B effective dates to the PEBB Program as proof of Medicare enrollment. If a subscriber or their dependent is not enrolled in either Medicare Part A or Part B on their 65th birthday, the subscriber must provide the PEBB Program with a copy of the denial letter from the Social Security Administration. The only exception to this rule is for an employee or school employee who retired on or before July 1, 1991.

Enrollment for subscribers and dependents

Deferring enrollment

A retiring employee, a retiring school employee, or a dependent becoming eligible as a survivor may defer (postpone) enrollment in PEBB retiree insurance coverage if they meet the substantive eligibility requirements to enroll and also meet the procedural requirement by submitting a **PEBB Retiree Election Form (form A)** to the PEBB Program within the enrollment timelines.

Deferring enrollment in PEBB retiree insurance coverage will also defer enrollment for all eligible dependents, except as described below.

A retiring employee, a retiring school employee, or a dependent becoming eligible as a survivor who does not enroll in PEBB retiree insurance coverage is only eligible to enroll later if they have deferred enrollment for one or more of the qualifying coverages below:

- Beginning January 1, 2001, enrollment in PEBB retiree insurance coverage may be deferred when the subscriber is enrolled in employer-based group medical insurance as an employee or the dependent of an employee, or such medical insurance continued under Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or continuation coverage.
- Beginning January 1, 2001, enrollment in PEBB retiree insurance coverage may be deferred when the subscriber is enrolled as a retiree or the dependent of a retiree in a federal retiree medical plan.
- Beginning January 1, 2006, enrollment in PEBB retiree insurance coverage may be deferred when the subscriber is enrolled in Medicare Parts A and B and a Medicaid program that provides creditable coverage. Eligible dependents who are not enrolled in Medicaid coverage that provides creditable coverage may be enrolled.
- Beginning January 1, 2014, subscribers who are not eligible for Medicare Part A and Part B may defer enrollment in PEBB retiree insurance coverage when the subscriber is enrolled in qualified health plan coverage through a health benefit exchange developed under the Affordable Care Act.
- Beginning July 17, 2018, enrollment in PEBB retiree insurance coverage may be deferred when the subscriber is enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

Exception: A retiree may defer enrollment in PEBB retiree insurance coverage during the period of time they are enrolled as a dependent in a medical plan sponsored by PEBB, a Washington State educational service district, or School Employees Benefits Board (SEBB), including such coverage under COBRA or continuation coverage. They do not need to submit a **PEBB Retiree Election Form**.

If a retiree or a survivor chooses to defer enrollment in PEBB medical, enrollment in PEBB dental will also be deferred.

Enrollment in PEBB retiree insurance coverage is automatically deferred if a retiree or a survivor becomes eligible for the employer contribution toward PEBB benefits. They do not need to submit a **PEBB Retiree Election Form**.

If a retiree or a survivor becomes eligible for the employer contribution toward SEBB benefits and enrolls in a SEBB health plan, they may request to defer enrollment in PEBB retiree insurance coverage.

A retiree or a survivor who deferred their enrollment in PEBB retiree insurance coverage may enroll as described in "Enrollment following deferral" later in this section.

Retiree and survivor enrollment
An eligible retiree, a survivor, or their dependent can enroll in only one PEBB medical plan, even if eligibility criteria is met under two or more subscribers.

An eligible retiring employee or a retiring school employee must submit a **PEBB Retiree Election Form (form A)** along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 60 days after the employee's or the school employee's employer-paid coverage, COBRA coverage, or continuation coverage ends. The first

premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible elected or full-time appointed official must submit a **PEBB Retiree Election Form (form A)** along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 60 days after the official leaves public office. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible survivor of a retiree must submit a **PEBB Retiree Election Form (form A)** along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 60 days after the death of the retiree.

An eligible survivor of an employee or school employee must submit a **PEBB Retiree Election Form (form A)** along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 60 days after the later of the date of the employee's or the school employee's death, or the date the survivor's PEBB insurance coverage, educational service district coverage, or SEBB insurance coverage ends. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible employee or school employee determined to be retroactively eligible for disability retirement must submit a **PEBB Retiree Election Form (form A)** along with any other required forms, supporting documents, and their formal determination letter to the PEBB Program. They must be received no later than 60 days after the date on the determination letter. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible survivor of an emergency service personnel killed in the line of duty must submit a **PEBB Retiree Election Form (form A)** along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 180 days after the later of:

- The date on the letter from the Department of Retirement Systems or the Board for Volunteer Firefighters and Reserve Officers that informs the survivor that they are determined to be an eligible survivor;
- The date of the emergency service worker's death; or
- The last day the survivor was covered under any health plan through the emergency service worker's employer or COBRA coverage from the emergency service worker's employer.

A retiree or a survivor who deferred enrollment and is enrolling in a PEBB retiree health plan, must submit a **PEBB Retiree Election Form (form A)** along with any other required forms, supporting documents, and evidence of continuous enrollment to the PEBB Program. They must be received no later than 60 days after a loss of other qualifying coverage. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends. See "Enrollment following deferral" for additional enrollment timelines.

Note: Enrollment in the Kaiser Permanente WA Medicare Advantage plan may not be retroactive. If a subscriber is eligible for and elects this plan and the required forms are received by the PEBB Program after the date PEBB retiree insurance coverage is to begin, the subscriber

and their enrolled dependents will be enrolled in another Kaiser Permanente WA plan during the gap month(s) prior to when the Kaiser Permanente WA Medicare Advantage plan begins.

Dependent enrollment
To enroll an eligible dependent, the subscriber must include the dependent's information on the applicable enrollment form and provide the required document(s) as proof of the dependent's eligibility. The dependent will not be enrolled in PEBB health plan coverage if the PEBB Program is unable to verify their eligibility within the PEBB Program enrollment timelines.

Dependents who are enrolled in medical coverage must be enrolled in the same PEBB medical plan as the retiree or survivor.

Exception: If a retiree or a survivor selects a Kaiser Permanente WA Medicare plan, they must also select the Kaiser Permanente WA Classic, SoundChoice, or Value plan for non-Medicare enrollees.

A retiree or a survivor may also enroll an eligible dependent during the PEBB Program's annual open enrollment or during a special open enrollment. See "Making changes" later in this section.

Medicare eligibility and enrollment

Medicare Part A and Part B
If a subscriber or their enrolled dependent becomes eligible for Medicare, they should contact the Social Security Administration to ask about Medicare enrollment.

Any enrollee who is eligible for Medicare must enroll and stay enrolled in Medicare Part A and Part B to continue enrollment in a PEBB retiree health plan.

In most cases, Medicare will become the primary insurance coverage and the PEBB retiree medical plan will become the secondary insurance coverage.

A subscriber must provide a copy of their or their dependent's Medicare card or entitlement letter from the Social Security Administration with effective dates to the PEBB Program. If a subscriber or their dependent is not enrolled in either Medicare Part A or Part B on their 65th birthday, the subscriber must provide the PEBB Program with a copy of the denial letter from the Social Security Administration. If this procedural requirement is not met, eligibility will end as described in the termination notice sent by the PEBB Program. The only exception to this rule is for an employee or school employee who retired on or before July 1, 1991.

Medicare Part D
The PEBB Program has determined that this medical plan has prescription drug coverage that is, on average, as good as or better than the standard Medicare Part D prescription drug coverage (it is "creditable coverage"). Therefore, a subscriber or their enrolled dependent cannot enroll in a Medicare Part D plan and stay in this medical plan.

If the subscriber terminates this medical plan, they may contact the PEBB Program to request a certificate of creditable coverage. If creditable prescription drug coverage is not maintained, Medicare Part D premiums may be higher in the future.

If a subscriber, or their enrolled dependent chooses to enroll in a Medicare Part D plan, PEBB retiree insurance coverage may only be continued by enrolling in the PEBB-sponsored Medicare supplement plan.

When medical coverage begins

For an eligible retiring employee or retiring school employee and their eligible dependents, medical coverage begins the first day of the month after the employer-paid coverage, COBRA coverage, or continuation coverage ends.

For an eligible employee or school employee determined to be retroactively eligible for disability retirement and their eligible dependents, medical coverage begins on the date chosen by the employee or school employee as allowed under PEBB Program rules.

For an eligible elected or full-time appointed official and their eligible dependents, medical coverage begins the first day of the month following the date the official leaves public office.

For an eligible survivor of a retiree and their eligible dependents, medical coverage will be continued without a gap, subject to payment of premiums and applicable premium surcharges. If the eligible survivor is not enrolled at the time of the retiree's death, medical coverage will begin the first day of the month following the retiree's death.

For an eligible survivor of an employee or school employee and their eligible dependents, medical coverage begins the first day of the month following the later of the date of the employee's or the school employee's death or the date the survivor's PEBB insurance coverage, educational service district coverage, or SEBB insurance coverage ends. This does not include emergency service personnel killed in the line of duty.

For an eligible survivor of an emergency service personnel killed in the line of duty and their eligible dependents, medical coverage begins on the date chosen, as allowed under PEBB Program rules.

For a retiree or a survivor who deferred enrollment and is enrolling in a PEBB retiree health plan following loss of other qualifying coverage, medical coverage for the retiree or the survivor and their eligible dependents begins the first day of the month after the loss of the other qualifying coverage.

For a retiree, a survivor, or their eligible dependents enrolling during the PEBB Program's annual open enrollment, medical coverage begins January 1 of the following year.

For a retiree, a survivor, or their eligible dependents enrolling during a special open enrollment, medical coverage begins the first of the month following the later of the event date or the date the required form is received. If that day is the first of the month, medical coverage begins on that day.

If the special open enrollment is **due to the birth or adoption of a child**, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, medical coverage will begin as follows:

- For a newly born child, medical coverage will begin the date of birth;
- For a newly adopted child, medical coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier; or
- For a spouse or state registered domestic partner of a subscriber, medical coverage will begin the first day of the month in which the event occurs.

If the special open enrollment is due to the enrollment of an extended dependent or a dependent child with a disability, medical coverage will begin the first day of the month following the later of the event date or eligibility certification, whichever is later.

Making changes

Removing a dependent who is no longer eligible
A subscriber must provide notice to the PEBB Program to remove a dependent who is no longer eligible due to divorce, annulment, dissolution, or a qualifying event of a dependent ceasing to be eligible as a dependent child, as described under "Dependent eligibility" earlier in this section. The notice must be received within 60 days of the last day of the month the dependent no longer meets the eligibility criteria.

Consequences for not submitting notice within the required 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue PEBB medical coverage under one of the continuation coverage options described in "Options for continuing PEBB medical coverage" later in this section.
- The subscriber may be billed for claims paid by the medical plan for services that were rendered after the dependent lost eligibility.
- The subscriber may not be able to recover subscriber-paid insurance premiums for the dependent that lost eligibility.
- The subscriber may be responsible for premiums paid by the state for the dependent's medical plan coverage after the dependent lost eligibility.

Voluntary termination
An enrolled retiree or survivor may voluntarily terminate enrollment in a medical plan at any time by submitting a request in writing to the PEBB Program. Enrollment in the medical plan will be terminated the last day of the month in which the PEBB Program receives the request or on the last day of the month specified in the termination request, whichever is later. If the request is received on the first day of the month, medical plan enrollment will be terminated on the last day of the previous month. When a retiree, a survivor, or their dependent is enrolled in a Medicare Advantage plan, medical plan enrollment will be terminated on the last day of the month when the **Medicare Advantage Plan Disenrollment Form (form D)** is received.

A retiree or a survivor who voluntarily terminates their enrollment in a medical plan also terminates all other health plan enrollment and enrollment for all eligible dependents. Once coverage is terminated, a retiree or a survivor may not enroll again in the future unless they reestablish eligibility for PEBB insurance coverage by becoming newly eligible.

Deferring enrollment
An enrolled retiree or survivor may defer enrollment in PEBB retiree insurance coverage at any time by submitting the **PEBB Retiree Change Form (form E)** along with any other required forms and supporting documents to the PEBB Program. Enrollment in PEBB retiree insurance coverage will be deferred effective the first of the month following the date the required forms are received. If the forms are received on the first day of the month, enrollment will be deferred effective that day. When a retiree, a survivor, or their dependent is enrolled in a Medicare

Advantage plan, medical plan enrollment will be deferred the first of the month following the date the **Medicare Advantage Plan Disenrollment Form (form D)** is received. A retiree or a survivor who deferred their enrollment may enroll as described in "Enrollment following deferral" below.

Enrollment following deferral
A retiree or a survivor who defers enrollment in PEBB retiree insurance coverage:

- **While enrolled in employer-based group medical or such coverage under COBRA coverage or continuation coverage** may enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after the date their enrollment in employer-based group medical coverage or such coverage under COBRA coverage or continuation coverage ends.
- **While enrolled in a federal retiree medical plan as a retiree or dependent** will have a one-time opportunity to enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after their enrollment in a federal retiree medical plan ends.
- **While enrolled in Medicare Parts A and B and a Medicaid program that provides creditable coverage** may enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after their Medicaid coverage ends, or no later than the end of the calendar year when their Medicaid coverage ends if they were also enrolled in a subsidized Medicare Part D plan.
- **While enrolled in qualified health plan coverage through a health benefit exchange** developed under the Affordable Care Act will have a one-time opportunity to enroll or reenroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after exchange coverage ends.
- **While enrolled in CHAMPVA** will have a one-time opportunity to enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after their enrollment in a CHAMPVA medical plan ends.
- **While enrolled as a dependent in a medical plan** sponsored by PEBB, a Washington State educational service district, or SEBB, including coverage under COBRA or continuation coverage, may enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after the enrollment in a medical plan sponsored by PEBB, a Washington State educational service district, or SEBB ends, or such coverage under COBRA or continuation coverage ends.

Note: Enrollment in the Kaiser Permanente WA Medicare Advantage plan may not be retroactive. If a subscriber is eligible for and elects this plan and the required forms are received by the PEBB Program after the date PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in another Kaiser Permanente WA plan during the gap month(s) prior to when the Kaiser Permanente WA Medicare Advantage plan begins.

For a retiree or a survivor to enroll in a PEBB medical plan, the PEBB Program must receive a **PEBB Retiree Election Form (form A)**, any other required forms, supporting documents, and evidence of continuous enrollment in one or more qualifying coverages during the timelines described in this section. A gap in coverage of 31 days or less is allowed between the date PEBB

retiree insurance coverage is deferred and the start date of a qualifying coverage, and between each period of enrollment in qualifying coverages during the deferral period.

A retiree or a survivor who deferred their enrollment in PEBB retiree insurance coverage while enrolled in qualifying coverage as described above may also enroll in a PEBB medical plan if they receive formal notice that HCA has determined it is more cost-effective to enroll in a PEBB medical plan than a medical assistance program.

A retiree or a survivor should contact the PEBB Program or visit **hca.wa.gov/pebb-retirees** to get the required forms, information on premiums, and a list of available medical plans.

Making changes during annual open enrollment and special open enrollment
A subscriber may make certain changes to their enrollment during the annual open enrollment and if a specific life event creates a special open enrollment period.

Annual open enrollment changes
A subscriber may make the following changes to their enrollment during the PEBB Program's annual open enrollment period:

- Enroll in a medical plan following a deferral
- Defer or terminate their enrollment in a medical plan
- Enroll or remove eligible dependents
- Change their medical plan

A subscriber must submit the election change online in PEBB My Account or return the required **PEBB Retiree Election Form (form A-OE)** along with any other required forms, and any supporting documents to the PEBB Program. The change must be completed in PEBB My Account or the forms must be received no later than the last day of the annual open enrollment period and will be effective January 1 of the following year.

Special open enrollment changes
A subscriber may change their enrollment outside of the annual open enrollment period if a qualifying event creates a special open enrollment period. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, their dependent, or both.

The subscriber must provide evidence of the event that created the special open enrollment.

To disenroll from a Medicare Advantage plan or Medicare Advantage-Prescription Drug plan, the change in enrollment must be allowable under federal regulations.

To make an enrollment change, the subscriber must submit the required **PEBB Retiree Change Form (form E)** along with any other required forms to the PEBB Program. The PEBB Program must receive the forms no later than 60 days after the event that creates the special open enrollment. In addition, the PEBB Program will require the subscriber to provide proof of the dependent's eligibility, evidence of the event that created the special open enrollment, or both.

Exceptions:

- A subscriber enrolled in PEBB retiree insurance coverage has six months from the date of their or their dependent's enrollment in Medicare Part B to change their enrollment to a PEBB Medicare Supplement Plan. The PEBB Program must receive the required form(s) no later than six months after the enrollment in Medicare Part B for either the subscriber or their dependent.
- When a subscriber or their dependent is enrolled in a Medicare Advantage or Medicare Advantage-Prescription Drug plan, they may disenroll during a special enrollment period as allowed under federal regulations. The new medical plan coverage will begin the first day of the month following the date the **Medicare Advantage Plan Disenrollment Form (form D)** is received.
- A subscriber enrolled in PEBB retiree insurance coverage has seven months to enroll in a Medicare Advantage or Medicare Advantage-Prescription Drug plan that begins three months before they or their dependent first enrolled in both Medicare Part A and Part B and ends three months after the month of Medicare eligibility. A subscriber may also enroll themselves or their dependent in a Medicare Advantage or Medicare Advantage-Prescription Drug plan before their last day of the Medicare Part B initial enrollment period. The forms must be received by the PEBB Program no later than the last day of the month prior to the month the subscriber or their dependent enrolls in the Medicare Advantage or Medicare Advantage-Prescription Drug plan.
- If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should notify the PEBB Program by submitting the required form(s) as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required form(s) must be received no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

Special open enrollment events that allow for a change in health plans

A subscriber may not change their health plan if their state-registered domestic partner or state-registered domestic partner's child is not a tax dependent.

Any of the following events may create a special open enrollment:

- Subscriber gains a new dependent due to:
  - Marriage or registering a state-registered domestic partnership.
  - Birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
  - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
- Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).

- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.
- Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber moves and their current health plan is not available in the new location, the subscriber must select a new health plan, otherwise there will be limited accessibility to network providers and covered services.
- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent).
- Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or their dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- Subscriber or their dependent enrolls in coverage under Medicare, or the subscriber or their dependent loses eligibility for coverage under Medicare or enrolls in or terminates enrollment in a Medicare Advantage Prescription Drug or a Part D plan. If the subscriber's current medical plan becomes unavailable due to the subscriber's or their dependent's enrollment in Medicare the subscriber must select a new medical plan.
- Subscriber or their dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA).
- Subscriber or their dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the subscriber or their dependent. The subscriber may not change their health plan election because the subscriber's or dependent's physician stops participation with the subscriber's health plan unless the PEBB Program determines that a continuity of care issue exists. The PEBB Program will consider but not limit its consideration to the following:
  - Active cancer treatment, such as chemotherapy or radiation therapy
  - Treatment following a recent organ transplant
  - A scheduled surgery
  - Recent major surgery still within the postoperative period
  - Treatment for a high-risk pregnancy.

Note: The plan cannot guarantee that any physician, hospital, or other provider will be available or remain under contract with the plan. An enrollee may not change medical plans simply because their provider or health care facility discontinues participation with this medical plan until the PEBB Program's next annual open enrollment or when another qualifying event creates

a special open enrollment for changing health plans, unless the PEBB Program determines that a continuity of care issue exists.

Special open enrollment events that allow adding or removing a dependent
Any of the following events may create a special open enrollment:

- Subscriber gains a new dependent due to:
  - Marriage or registering a state-registered domestic partnership.
  - Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption.
  - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
- Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.
- Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance.
- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent).
- Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP) or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or their dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- Subscriber's dependent enrolls in Medicare or loses eligibility for Medicare.

When medical coverage ends

Termination dates
Medical coverage ends on the following dates:

- On the last day of the month when any enrollee ceases to be eligible.

- On the date a medical plan terminates due to a change in contracted service area or when the group policy ends. If that should occur, the subscriber will have the opportunity to enroll in another PEBB medical plan.
- On the last day of the month in which the monthly premium and applicable premium surcharges were paid.
- The first of the month following the date the required forms are received when an enrolled retiree or survivor requests to defer enrollment in PEBB retiree insurance coverage. If the forms are received on the first day of the month, enrollment will be deferred effective that day. When a retiree, a survivor, or their dependent is enrolled in a Medicare Advantage plan, medical plan enrollment will be deferred the first of the month following the date the **Medicare Advantage Plan Disenrollment Form (form D)** is received.
- The last day of the month in which the PEBB Program receives a written request and all required forms requesting to voluntarily terminate enrollment in a medical plan. If a future date is specified, medical coverage terminates the last day of the month specified. If the termination request is received on the first day of the month, medical plan enrollment will be terminated on the last day of the previous month. When a retiree, a survivor, or their dependent is enrolled in a Medicare Advantage plan, medical plan enrollment will be terminated on the last day of the month when the **Medicare Advantage Plan Disenrollment Form (form D)** is received.

A subscriber will be responsible for payment of any services received after the date medical coverage ends, as described above.

Final premium payments
The subscriber is responsible for timely payment of premiums and applicable premium surcharges.

Premium payments and applicable premium surcharges are not prorated during any month, for any reason, even if an enrollee dies or asks to terminate their medical plan before the end of the month.

If the monthly premium or applicable premium surcharges remain unpaid for 30 days, it will be considered delinquent. A subscriber is allowed a grace period of 30 days from the date the monthly premium or applicable premium surcharges become delinquent to pay the unpaid premium balance or applicable premium surcharges. If the subscriber's premium balance or applicable premium surcharges remain unpaid for 60 days from the original due date, coverage will be terminated retroactive to the last day of the month for which the monthly premium and any applicable premium surcharges were paid.

For a subscriber enrolled in a Medicare Advantage or Medicare Advantage-Prescription Drug plan, a notice will be sent to them notifying them that they are delinquent on their monthly premiums and that the enrollment will be terminated prospectively to the end of the month after the notice is sent.

If an enrollee is hospitalized
An enrollee who is receiving covered services in a hospital on the date medical coverage ends will continue to be eligible for covered services while an inpatient for the condition which the enrollee was hospitalized, until one of the following events occur:

- According to this plan's clinical criteria, it is no longer medically necessary for the enrollee to be an inpatient at the facility.
- The remaining benefits available for the hospitalization are exhausted, regardless of whether a new calendar year begins.
- The enrollee becomes covered under another agreement with a group health plan that provides benefits for the hospitalization.
- The enrollee becomes enrolled under an agreement with another carrier that provides benefits for the hospitalization.

This provision will not apply if the enrollee is covered under another agreement that provides benefits for the hospitalization at the time medical coverage ends, except as set forth in this section, or if the enrollee is eligible for PEBB Continuation Coverage as described in "Options for continuing PEBB medical coverage."

Options for continuing PEBB medical coverage
A subscriber and their dependents covered by this medical plan may be eligible to continue enrollment under PEBB Continuation Coverage (COBRA) if they lose eligibility. PEBB Continuation Coverage (COBRA) temporarily extends group insurance coverage if certain circumstances occur that would otherwise end the subscriber or their dependent's PEBB medical coverage. PEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements under federal COBRA laws and regulations and also includes coverage for some enrollees who are not qualified beneficiaries under federal COBRA continuation coverage.

The PEBB Program administers this coverage. Call the PEBB Program at **1-800-200-1004** (TRS: **711**) or refer to the **PEBB Continuation Coverage Election Notice** for details.

Options for continuing coverage under PEBB Retiree Insurance Coverage
A dependent becoming eligible as a survivor of a retiree is eligible to continue enrollment or defer enrollment in PEBB retiree insurance coverage if they meet procedural and substantive eligibility requirements. See the **PEBB Retiree Enrollment Guide** for details.

Conversion of coverage
An enrollee (including a spouse or dependent of a subscriber terminated for cause) has the right to switch from PEBB group medical to an individual conversion plan offered by this plan when they are no longer eligible to continue the PEBB group medical plan and are not eligible for Medicare or covered under another group insurance coverage that provides benefits for hospital or medical care.

An enrollee must apply for conversion coverage and pay the first month's premium no later than 31 days after their group medical plan ends or within 31 days from the date the notice of termination of coverage is received, whichever is later.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. Rates, coverage, and eligibility requirements of this conversion plan differ from those of the

enrollee's current group medical plan. To receive detailed information on conversion options under this medical plan, call Member Services.

General provisions for eligibility and enrollment

Termination for just cause
The purpose of this provision is to allow for a fair and consistent method to process the plan-designated provider's request to terminate an enrollee's coverage from this plan for just cause.

A retiree or eligible dependent may have coverage terminated by HCA for the following reasons:

- Failure to comply with the PEBB Program's procedural requirements, including failure to provide information or documentation requested by the due date in written requests from the PEBB Program.
- Knowingly providing false information.
- Failure to pay the monthly premium and applicable premium surcharges when due.
- Misconduct. Examples of such termination include, but are not limited to the following:
  - Fraud, intentional misrepresentation or withholding of information the subscriber knew or should have known was material or necessary to accurately determine eligibility or the correct premium.
  - Abusive or threatening conduct repeatedly directed to an HCA employee, a health plan, or other HCA-contracted vendor providing PEBB insurance coverage on behalf of HCA, its employees, or other persons.

If a retiree's PEBB insurance coverage is terminated by HCA for the above reasons, PEBB insurance coverage for all of the retiree's eligible dependents is also terminated.

Appeal rights
Any enrollee may appeal a decision made by the PEBB Program regarding PEBB eligibility, enrollment, premium payments, or premium surcharges to the PEBB Appeals Unit.

Learn more at **hca.wa.gov/pebb-appeals**.

Fax: **360-763-4709**

Mail: Health Care Authority
Attn: PEBB Appeals Unit
PO Box 45504
Olympia, WA 98504-5504

Hand deliver: Health Care Authority
626 8th Avenue SE
Olympia, WA 98501

Any enrollee may appeal a decision regarding the administration of a PEBB medical plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment decisions.

Relationship to law and regulations
Any provision of this **Evidence of Coverage** that is in conflict with any governing law or regulation of Washington State is hereby amended to comply with the minimum requirements of such law or regulation.

PEBB customer service

For questions about PEBB retiree eligibility and enrollment, please call the PEBB Program at **1-800-200-1004** (TRS: **711**) or visit **hca.wa.gov/pebb-retirees**. For questions about Medicare, please call the Centers for Medicare and Medicaid Services (CMS) at **1-800-MEDICARE** or visit **www.medicare.gov**.

Section 2.3 – Here is our plan service area for Kaiser Permanente Medicare Advantage

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

Our service area includes these counties in Washington: **Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Spokane, Thurston, and Whatcom**. Also, our service area includes these parts of counties in Washington, **in the following ZIP codes only**:

- **Grays Harbor**: 98541, 98557, 98559, and 98568.
- **Mason**: 98524, 98528, 98546, 98548, 98555, 98584, 98588, and 98592.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Member Services to see if we have a plan in your new area. When you move, you will have a special enrollment period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

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

Section 2.4 – U.S. citizen or lawful presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify us if you are not eligible to remain a member on this basis. We must disenroll you if you do not meet this requirement.

Section 3 — Important membership materials you will receive

Section 3.1 – Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get services covered by our plan. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:

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

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

Section 3.2 – Provider Directory

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

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

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

If you don't have your copy of the **Provider Directory**, you can request a copy from Member Services.

Section 4 — Your monthly costs for our plan

Your costs may include the following:

- Plan premium (Section 4.1).
- Monthly Medicare Part B premium (Section 4.2).

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, review your copy of **Medicare & You** 2023 handbook, in the section called "2023 Medicare Costs." If you need a copy, you can download it from the Medicare website

(**www.medicare.gov**). Or, you can order a printed copy by phone at **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**.

Section 4.1 – Plan premium

Your coverage is provided through contract with your 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

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

Section 5 — More information about your monthly premium

Section 5.1 – Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for our plan's monthly plan premium during the year. If the monthly plan premium changes for next year, you will be notified by your former employer or union.

Section 6 — Keeping your plan membership record up-to-date

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

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

Let us know about these changes:

- Changes to your name, your address, or your phone number.
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid).
- If you have any liability claims, such as claims from an automobile accident.
- If you have been admitted to a nursing home.
- If you receive care in an out-of-area or out-of-network hospital or emergency room.
- If your designated responsible party (such as a caregiver) changes.

- If you are participating in a clinical research study. (**Note**: You are not required to tell your plan about the clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, please let us know by calling Member Services. Also, you may tell us about these changes at **kp.org** by selecting "contact Member Services" and sending us an email or chat message.

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

Section 7 — How other insurance works with our plan

Other insurance

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

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

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

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

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

- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

Chapter 2 — Important phone numbers and resources

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

How to contact our plan's Member Services

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

METHOD	Member Services – contact information
CALL	**1-888-901-4600** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Kaiser Permanente Member Services P.O. Box 34590 Seattle, WA 98124 E-mail: **kp.org** and click on "Contact Us"
WEBSITE	**kp.org**

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes.

For more information about asking for a coverage decision or making a complaint about your medical care, see Chapter 7, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." You may call us if you have questions about our coverage decision or complaint processes.

METHOD	Coverage decisions or complaints about medical care – contact information
CALL	**1-888-901-4600**

METHOD	Coverage decisions or complaints about medical care – contact information
	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	**1-888-874-1765**
WRITE	Kaiser Permanente Member Services P.O. Box 34590 Seattle, WA 98124
WEBSITE	**kp.org**
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to **www.medicare.gov/MedicareComplaintForm/home.aspx.**

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information about making an appeal about your medical care, see Chapter 7, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)."

METHOD	Appeals for medical care – contact information
CALL	**1-866-458-5479** Calls to this number are free. Monday through Friday, 8 a.m. to 5 p.m.
TTY	**711** Calls to this number are free. Monday through Friday, 8 a.m. to 5 p.m.
FAX	**1-206-630-1859**
WRITE	Kaiser Permanente Medicare Appeals Coordinator P.O. Box 34593 Seattle, WA 98124-1593 E-mail: **kp.org** and click on "Contact Us"
WEBSITE	**kp.org**

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

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 5, "Asking us to pay our share of a bill you have received for covered medical services or drugs."

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," for more information.

METHOD	Payment requests – contact information	
WRITE	For medical care write to: Kaiser Permanente Claims Department P.O. Box 30766 Salt Lake City, UT 84130-0766	For Medicare without Part D drugs write to: OptumRX PO Box 650334 Dallas, TX 75265-0334
WEBSITE	**kp.org/wa/reimburse**	

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

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

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

METHOD	Medicare – contact information
CALL	**1-800-MEDICARE** or **1-800-633-4227** Calls to this number are free. 24 hours a day, 7 days a week.
TTY	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	**www.medicare.gov** This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health

METHOD	Medicare – contact information
	agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options, with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about our plan: • **Tell Medicare about your complaint:** You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to **www.medicare.gov/MedicareComplaintForm/home.aspx.** Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.)

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Washington, the SHIP is called the Statewide Health Insurance Benefits Advisors (SHIBA).

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

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

Method to access SHIP and other resources:

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

METHOD	Statewide Health Insurance Benefits Advisors (Washington's SHIP) – contact information
CALL	**1-800-562-6900**
TTY	**1-360-586-0241** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	SHIBA Office of the Insurance Commissioner P.O. Box 40255 Olympia, WA 98504-0255
WEBSITE	**www.insurance.wa.gov/shiba**

Section 4 — Quality Improvement Organization

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

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

You should contact KEPRO in any of these situations:

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

METHOD	KEPRO (Washington's Quality Improvement Organization) – contact information
CALL	**1-888-305-6759**

METHOD	KEPRO (Washington's Quality Improvement Organization) – contact information
	Calls to this number are free. Monday through Friday, 9 a.m. to 5 p.m. Weekends and holidays, 11 a.m. to 3 p.m.
TTY	**1-855-843-4776** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131
WEBSITE	**www.keproqio.com**

Section 5 — Social Security

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

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

METHOD	Social Security – contact information
CALL	**1-800-772-1213** Calls to this number are free. Available 8 a.m. to 7 p.m., Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	**1-800-325-0778** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 a.m. to 7 p.m., Monday through Friday.
WEBSITE	**www.ssa.gov**

Section 6 — Medicaid

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

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

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

To find out more about Medicaid and its programs, contact Washington State Department of Social and Health Services.

METHOD	Washington State Department of Social and Health Services – contact information
CALL	**1-877-501-2233** Monday through Friday, 8 a.m. to 5 p.m.
TTY	**711**
WRITE	Washington State Department of Social and Health Services 1115 Washington St. SE Olympia, WA 98504
WEBSITE	**washingtonconnection.org**

Section 7 — How to contact the Railroad Retirement Board

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

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

Section 8 — Do you have "group insurance" or other health insurance from an employer?

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

Chapter 3 — Using our plan for your medical services

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

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

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4, "Medical Benefits Chart (what is covered and what you pay)."

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

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment, that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

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

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

We will generally cover your medical care as long as:

- **The care you receive is included in our plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary.** "Medically necessary" means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider** (a PCP) who is providing and overseeing your care. As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).

- In most situations, your network PCP must give you a referral in advance before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral" (for more information about this, see Section 2.3 in this chapter).
- Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 in this chapter).

- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. Here are five exceptions:
  - We cover emergency or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost-sharing you normally pay in-network if we authorize the services before you get the care. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
  - We cover kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost-sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside our plan's network, the cost-sharing for the dialysis may be higher.
  - If you visit Arizona, you can get covered care from designated providers in Maricopa and Pima counties. Please call Member Services for provider locations and see Chapter 4Section 2.2, for more information about this benefit.
  - Care you receive from network providers in other Kaiser Permanente regions described in Section 2.3 in this chapter.

Section 2 — Use providers in our network to get your 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) and sometimes obstetrics/gynecology. At some network facilities, if you prefer, you may choose an available nurse practitioner or physician assistant to be your primary care provider. PCPs are identified in the **Provider Directory**.

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

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

How do you choose or change your PCP?

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

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

- Routine women's health care, which includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider.
- Flu shots, COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.)
- Chiropractic services, as long as you get them from a network provider.
- Routine eye exams, as long as you get them from a network provider.
- Mental health and substance abuse care from specialists at a Kaiser Permanente owned and operated facility.
- Acupuncture not covered by Medicare as long as you get them from a network provider.
- Naturopathy as long as you get them from a network provider.

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

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

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

Referrals from your PCP

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

Referrals to network providers
When your PCP prescribes care that isn't available from a PCP (for example, specialty care), he or she will give you a referral to see a network specialist or another network provider as needed. If your PCP refers you to a network specialist, the referral will be for specific services. 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.

For some types of network specialty care, your PCP may need to get approval in advance from our plan. If there is a particular network specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist.

Prior authorization

For the services and items listed below, your network provider will need to get approval in advance from our plan or Medical Group (this is called getting "prior authorization"). Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals. If you ever disagree with authorization decisions, you can file an appeal as described in Chapter 5.

- Services and items identified in Chapter 4 with a footnote (†).
- For certain network specialty care, your PCP will need to request that we authorize the referral before you can see the specialty care network provider. If we authorize the referral, it will be for specific services as explained above (see "Referrals from your PCP to specialists" for details).
- If your network provider decides that you require covered services not available from network providers, he or she will recommend to Health Plan that you be referred to an out-of-network provider inside or outside our service area. The appropriate Health Plan 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 specific services. It specifies the duration of the referral without having to get additional approval from us. Please ask your PCP or Member Services 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. Transplant services must be provided through locally and nationally contracted or approved transplant centers. Please contact Member Services regarding preauthorization for transplants.

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

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

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure that the medically necessary treatment you are receiving is not interrupted.
- If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost-sharing. The appropriate Health Plan 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 specific services. It specifies the duration of the referral without having to get additional approval from us. Please ask your PCP or Member Services what services have been authorized if you are not certain. If the out-of-network specialist wants you to come back for more care, be sure to check if the referral covers the additional care. If it doesn't, please contact your network provider.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider, or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to our plan, or both. Please see Chapter 7.

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

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

- Emergency or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services mean, see Section 3 in this chapter.
- We 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 Arizona, you can get covered care from designated providers in Maricopa and Pima counties. Please call Member Services for provider locations and see Chapter 4, Section 2.2, for more information about this benefit.

- 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 Member Services at **1-888-901-4600** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week (except holidays), or visit our website at **kp.org/wa/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:** Member Services can also answer questions about covered emergency or urgent care services you receive out-of-network, including how to get reimbursement.

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

Section 3.1 – Getting care if you have a medical emergency

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

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

If you have a medical emergency:

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

What is covered if you have a medical emergency?

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

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

We will partner with the doctors who are providing the emergency care to help manage and follow up on your care. After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. We will cover your follow-up post-stabilization care in accord with Medicare guidelines. It is very important that your provider call us to get

authorization for post-stabilization care before you receive the care from the out-of-network provider. In most cases, you will only be held financially liable if you are notified by the out-of-network provider or us about your potential liability.

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

What if it wasn't a medical emergency?

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

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

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

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

What are "urgently needed services"?

An "urgently needed service" is a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. For example, an unforeseen flare-up of a known condition that you have or a severe sore throat that occurs over the weekend. Urgently needed services may be furnished by out of-network providers when it is unreasonable, given your circumstances, to obtain immediate care from network providers.

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 our Consulting Nurse Service Department at **1-800-297-6877** (TTY **711**).

To get urgent care during normal office hours, call your PCP's office or our Consulting Nurse Service. After hours including weekends and holidays, call our Consulting Nurse Service. Many of our urgent centers are open after hours and some are open 24 hours a day, 7 days a week. For urgent care center locations, please see your **Provider Directory**, call our Consulting Nurse Service, or visit **kp.org/directory**.

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

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

Section 3.3 – Getting care during a disaster

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

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

If you cannot use a network provider during a disaster, our plan will allow you to obtain care from out-of-network providers at in-network cost-sharing.

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

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

If you have paid more than your plan cost-sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5, "Asking us to pay our share of a bill you have received for covered medical services," for information about what to do.

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

We cover all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

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

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

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

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research

studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost-sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost-sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

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

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

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

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

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

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

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost-sharing in Original Medicare and your in-network cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 5 for more information for submitting requests for payments.

Here's an example of how the cost-sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is

$20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and you would pay the $20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you $10. Therefore, your net payment is $10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

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

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

Do you want to know more?

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

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

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

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

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

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to nonreligious aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - – and – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Note: Covered services are subject to the same limitations and cost-sharing required for services provided by network providers as described in Chapter 4 and Chapter 10.

Section 7 — Rules for ownership of durable medical equipment

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

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

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

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

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

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

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

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

What oxygen benefits are you entitled to?

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

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

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

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

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

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

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

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of our plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services. In addition, please see Chapter 3, Chapter 9, and Chapter 10 for additional coverage information, including limitations (for example, coordination of benefits, durable medical equipment, home health care, skilled nursing facility care, and third party liability).

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

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

- A **"copayment"** is a fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service unless we do not collect all cost-sharing at that time and send you a bill later. (The Medical Benefits Chart in Section 2 of this chapter tells you more about your copayments.)
- **"Coinsurance"** is a percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service unless we do not collect all cost-sharing at that time and send you a bill later. (The Medical Benefits Chart in Section 2 of this chapter tells you more about your coinsurance.)

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

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

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the amount you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2023 this amount is **$2,500**.

The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amount you pay for your plan premium does not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk (*) in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of **$2,500**, you will not have to pay any out-of-pocket costs for the rest of the year for in-

network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

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

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

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

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

The Medical Benefits Chart on the following pages lists the services we cover and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) must be medically necessary. "Medically necessary" means that the services, supplies,

or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered, unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in our plan's network. This is called giving you a "referral."
- Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart with a footnote (†). In addition, see Chapter 3, Section 2.3, for more information about prior authorization, including other services that require prior authorization that are not listed in the Medical Benefits Chart.

Other important things to know about our coverage

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

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.

Services that are covered for you	What you must pay when you get these services
Acupuncture for chronic low back pain Covered services include: • Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: ♦ For the purpose of this benefit, chronic low back pain is defined as: ○ 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. ○ Not associated with pregnancy. An additional eight sessions are covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • 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	**$15** per visit.

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
physician, PA, or NP/CNS required by regulations at 42 CFR §§ 410.26 and 410.27.	
Alternative Therapies Members may self-refer to network providers for up to: • 12 acupuncture visits per calendar year • 3 naturopathy visits per calendar year • 12 chiropractic visits for non spinal manipulation services per calendar year • 10 Massage therapy visits by a licensed massage therapist when medically necessary and referred by their provider. † Additional visits are not covered.	**$15** per acupuncture, naturopathy or chiropractic visit. **$30** per massage therapy visit.
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. • We also cover the services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) if you reasonably believe that you have an emergency medical condition and you reasonably believe that your condition requires the clinical support of ambulance transport services. • †Nonemergency transportation by ambulance if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	**$150** per one-way trip.

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
Annual routine physical exams Routine physical exams are covered if the exam is medically appropriate preventive care in accord with generally accepted professional standards of practice.	There is no coinsurance, copayment, or deductible for this preventive care.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement† For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39. • One screening mammogram every 12 months for women aged 40 and older. • Clinical breast exams once every 24 months.	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services† Comprehensive programs for cardiac rehabilitation services that include exercise, education, and	**$0**

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
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.	
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months. • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past three years: one Pap test every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation. ♦ These Medicare-covered services are provided by a network chiropractor. For the list of network chiropractors, please refer to the **Provider Directory**.	**$15** per visit.

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
Note: You have additional chiropractic coverage described earlier in this chart under "Acupuncture and chiropractic care not covered by Medicare."	
Colorectal cancer screening† • For people 50 and older, the following are covered: ♦ Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. ♦ One of the following every 12 months: ○ Guaiac-based fecal occult blood test (gFOBT). ○ Fecal immunochemical test (FIT). • DNA-based colorectal screening every 3 years. • For people at high risk of colorectal cancer, we cover a screening colonoscopy (or screening barium enema as an alternative) every 24 months. • For people not at high risk of colorectal cancer, we cover a screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.
• Procedures performed during a screening colonoscopy (for example, removal of polyps). • Colonoscopies following a positive gFOBT or FIT test or a flexible sigmoidoscopy screening. • Computed Tomography (CT) colonography (also known as a virtual colonoscopy) when medically necessary and criteria is met. • **Note**: All other colonoscopies are subject to the applicable cost-sharing listed elsewhere in this chart.	**$0**
Dental services† The services of a licensed dentist will be covered for repair of accidental injury to natural teeth. Evaluation of the injury and development of a written treatment plan must be completed within 30 days from the date of injury. Treatment must be completed within one year from the date of injury.	• You pay **$200** per day for days **1–5** of a hospital stay. Thereafter there is **no charge** for the remainder of your covered hospital stay. Also, you do not pay the copayment listed above for the day you are discharged unless you

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
	are admitted and discharged on the same day. • **$15** per visit for each visit to a licensed dentist for repair of accidental injury to natural teeth
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services, and supplies† For all people who have diabetes (insulin and noninsulin users), covered services include: • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the noncustomized removable inserts provided with such shoes). Coverage includes fitting.	**20%** coinsurance
• Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet	**20%** coinsurance

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
devices, lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.	
• 🍎 Diabetes self-management training is covered under certain conditions. • †**Note**: You may choose to receive diabetes self-management training from a program outside our plan that is recognized by the American Diabetes Association and approved by Medicare.	**$0**
Durable medical equipment (DME) and related supplies† (For a definition of "durable medical equipment," see Chapter 10 as well as Chapter 3Section 7, of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech-generating devices, oxygen equipment, nebulizers, and walkers. With this **Evidence of Coverage** document, we sent you our list of DME (see the back of this document for the list). The list tells you the brands and manufacturers of DME that we will cover. The most recent list of brands, manufacturers, and suppliers is also available on our website at **kp.org/directory**. Generally, we cover any DME covered by Original Medicare from the brands and manufacturers on this list. We will not cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to our plan and are using a brand of DME that is not on our list, we will continue to cover this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically appropriate for you after this 90-day period. (If you disagree with your doctor, you can ask him or her to refer you for a second opinion.)	**20%** coinsurance **Oxygen equipment** Your cost sharing for Medicare oxygen equipment coverage is **20%**, every time you receive equipment. Your cost sharing will not change after being enrolled for 36 months.

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
If you (or your provider) don't agree with our coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. For more information about appeals, see Chapter 7, "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)."	
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. **You have worldwide emergency care coverage.**	**$65** per Emergency Department visit This copayment does not apply if you are admitted directly to the hospital as an inpatient within 24 hours (it does apply if you are admitted to the hospital as an outpatient; for example, if you are admitted for observation). †If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost-sharing you would pay at a network hospital.
Fitness benefit (the Silver&Fit® Healthy Aging and Exercise Program) The Silver&Fit program includes the following: • You can join a participating Silver&Fit fitness center or multiple fitness centers and take advantage of the services that are included in the fitness center's standard membership (for example, use of fitness center equipment or instructor-led classes that do not require an additional fee). If you sign-up for a	**$0**

†Your provider must obtain prior authorization from our plan.

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

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

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
For more information about the Silver&Fit program and the list of participating fitness centers and home kits, visit **kp.org/SilverandFit** or call Silver&Fit customer service at **1-877-750-2746** (TTY **711**), Monday through Friday, 5 a.m. to 6 p.m. (PST). The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a federally registered trademark of ASH and used with permission herein. Participating fitness centers and fitness chains may vary by location and are subject to change.	
Hearing services • †Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	You pay the following depending upon the type of visit: **$15** per primary care visit. **$30** per specialty care visit.
• Hearing aids: ♦ We provide a **$1,400** allowance per ear that you can use to help pay for one hearing aid per ear every 60 months. If you do not use all of the allowance at the initial point of sale, you can use it later in that 60-month period. The hearing aids must be prescribed by a network provider (clinical audiologist). We select the provider or vendor that will furnish the covered hearing aid. Coverage is limited to the types and models of hearing aids furnished by the provider or vendor. ♦ This hearing aid benefit doesn't cover the following: ○ Internally implanted hearing aids. ○ Service packages that include adjustment, cleaning, and inspection of hearing aids after manufacturer's warranty.	*If the hearing aid(s) you purchase cost more than **$1,400** per ear, you pay the difference.
• †One hearing aid fitting and evaluation exam per 60-month period.	**$0**

†Your provider must obtain prior authorization from our plan.

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

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

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	
Home medical care not covered by Medicare (Advanced Care at Home) We cover medical care in your home that is not otherwise covered by Medicare when found medically appropriate by a physician based on your health status, to provide you with an alternative to receiving acute care in a hospital and post-acute care services in the home to support your recovery. Services in the home must be: • Prescribed by a network hospitalist who has determined that based on your health status, treatment plan, and home setting that you can be treated safely and effectively in the home. • Elected by you because you prefer to receive the care described in your treatment plan in your home. Medically Home is our network provider and will provide the following services and items in your home in accord with your treatment plan for as long as they are prescribed by a network hospitalist: • Home visits by RNs, physical therapists, occupational therapists, speech therapists, respiratory therapists, nutritionist, home health aides, and other healthcare professionals in accord with the home care treatment plan and the provider's scope of practice and license. • Communication devices to allow you to contact Medically Home's command center 24 hours a day, 7 days a week. This includes needed communication technology to support reliable communication, and an PERS alert device to contact Medically Home's command center if you are unable to get to a phone. • The following equipment necessary to ensure that you are monitored appropriately in your home: blood pressure cuff/monitor, pulse oximeter, scale, and thermometer. • Mobile imaging and tests such as X-rays, labs, and EKGs.	**$0**

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
• The following safety items: shower stools, raised toilet seats, grabbers, long handle shoehorn, and sock aid. Up to 21 meals per week while you are receiving acute care in the home.	
In addition, for Medicare-covered services and items listed below, the cost-sharing indicated elsewhere in this Medical Benefit Chart does not apply when the services and items are prescribed as part of your home treatment plan: • Durable medical equipment. • Medical supplies. • Ambulance transportation to and from network facilities when ambulance transport is medically necessary. • Physician assistant and nurse practitioner house calls or office visits. • The following services at a network facility if the services are part of your home treatment plan: ♦ Network Emergency Department visits associated with this benefit. ♦ Outpatient observation visits associated with this benefit. The cost-sharing indicated elsewhere in this Medical Benefit Chart will apply to all other services and items that aren't part of your home treatment plan (for example, DME unrelated to your home treatment plan) or are part of your home treatment plan, but are not provided in your home except as listed above. **Note:** For prescription drug cost-sharing information, please refer to the Medicare Part B prescription drug section in this chart and Chapter 6 for Medicare Part D prescription drugs.	**$0**
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your

†Your provider must obtain prior authorization from our plan.

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

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

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
For services that are covered by our plan but are not covered by Medicare Part A or B: We will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. **Note**: If you need nonhospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	
We cover hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	You pay the following depending upon the • **$20** per visit
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine. • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary. • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B. • COVID-19 vaccine. • Other vaccines if you are at risk and they meet Medicare Part B coverage rules.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.
Inpatient hospital care† Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. There is no limit to the number of medically necessary hospital days or services that are generally and customarily provided by acute care general hospitals. Covered services include, but are not limited to: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets.	Cost-sharing is charged for each inpatient stay. • **$200** per day for days 1–5 of a hospital stay. Thereafter you pay **$0** for the remainder of your covered hospital stay. Also, you do not pay the copayment listed above for the day you are discharged unless you are admitted and discharged on the same day. †If you get authorized inpatient care at an out-of-network hospital after your emergency condition is

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

Services that are covered for you	What you must pay when you get these services
• Regular nursing services. • Costs of special care units (such as intensive care or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical, occupational, and speech language therapy. • Inpatient substance abuse services for medical management of withdrawal symptoms associated with substance abuse (detoxification). • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If we provide transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion, in accord with our travel and lodging guidelines, which are available from Member Services. • Blood—including storage and administration. • Physician services.	stabilized, your cost is the cost-sharing you would pay at a network hospital.
Note: To be an "inpatient," your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet	

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient services in a psychiatric hospital† Covered services include mental health care services that require a hospital stay. • We cover up to 190 days per lifetime for inpatient stays in a Medicare-certified psychiatric hospital. The number of covered lifetime hospitalization days is reduced by the number of inpatient days for mental health treatment previously covered by Medicare in a psychiatric hospital. • The 190-day limit does not apply to mental health stays in a psychiatric unit of a general hospital.	Cost-sharing is charged for each inpatient stay. • **$200** per day for days 1–5 of a hospital stay. Thereafter you pay **$0** for the remainder of your covered hospital stay. Also, you do not pay the copayment listed above for the day you are discharged unless you are admitted and discharged on the same day.
Inpatient stay: Covered services received in a hospital or SNF during a noncovered inpatient stay† If you have exhausted your inpatient mental health or skilled nursing facility (SNF) benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient or SNF stay. However, in some cases, we will cover certain services you receive while you are in the hospital or SNF. Covered services include, but are not limited to: • Physician services. • Diagnostic tests (like lab tests). • X-rays, radium, and isotope therapy, including technician materials and services. • Surgical dressings. • Splints, casts, and other devices used to reduce fractures and dislocations. • 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	If your inpatient or SNF stay is no longer covered, we will continue to cover Medicare Part B services at the applicable cost-sharing listed elsewhere in this Medical Benefits Chart when provided by network providers.

†Your provider must obtain prior authorization from our plan.

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

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

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
Medicare Part B prescription drugs† These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan. • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant. • Certain oral anti-cancer drugs and anti-nausea drugs. • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases. • ***Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services. • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Antigens. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa).	You pay **$0** for up to a 30-day supply when obtained from a network pharmacy.
Note: • We also cover some vaccines under our Part B prescription drug benefit. • Drugs subject to step therapy are identified with three asterisks (***) above. Also, the following link will take you to a list of Part B drugs that may be subject to step therapy **https://healthy.kaiserpermanente.org/washington/support/medicare-health-plans-2023**.	

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

Services that are covered for you	What you must pay when you get these services
Obesity screening and therapy to promote sustained weight loss† If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services† Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable).	You pay **$0** for clinically administered Medicare Part B drugs when provided by an Opioid Treatment Program.
• Substance use counseling. • Individual and group therapy. • Toxicology testing. • Intake activities. • Periodic assessments.	**$30** per visit.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • Laboratory tests. • X-rays. • †Blood—including storage and administration. • †Electrocardiograms (EKGs) and electroencephalograms (EEGs). • †Genetic testing when testing guidelines are met. • †Sleep studies. • †Holter monitoring. • †Radiation (radium and isotope) therapy, including technician materials and supplies. • †Other outpatient diagnostic tests:	**$0**

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
♦ Magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET). ♦ Ultrasounds.	
• †Surgical supplies, such as dressings. • †Splints, casts, and other devices used to reduce fractures and dislocations.	**20%** coinsurance
♦ †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.	**$200** 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 the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf** or by calling	**$200** per stay when admitted directly or transferred from the Emergency Department to the hospital for observation as an outpatient. **Note**: There's no additional charge for outpatient observation stays when transferred for observation following outpatient surgery.

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
1-800-MEDICARE (1-800-633-4227). TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	
Outpatient hospital services† We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an Emergency Department or outpatient clinic, such as observation services or outpatient surgery.	**Emergency Department** **$65** per visit. †**Outpatient surgery** **$200** 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.	**$0**
• X-rays and other radiology services billed by the hospital.	**X-rays** **$0** **Radiation therapy** **$0** **MRI, CT, and PET** **$0** per MRI, CT, or PET.
• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it.	**$0** per day for partial hospitalization.
• Medical supplies such as splints and casts.	**20%** coinsurance
• Certain drugs and biologicals that you can't give yourself.	**$0**
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	
Outpatient mental health care†	• **$15** per individual therapy visit.

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
Covered services include: • Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	• **$15** per group therapy visit.
Outpatient prescription drugs* Drugs, Medicines, Supplies and Devices. This benefit, for purposes of creditable coverage, is actuarially equal to or greater than the Medicare Part D prescription drug benefit. All drugs, including contraceptive drugs and devices, are covered when prescribed by a network Provider for covered conditions and obtained at a network pharmacy and, unless approved by Kaiser Permanente in advance, be listed in the Kaiser Permanente drug formulary. Drug formulary (approved drug list) is defined as a list of preferred pharmaceutical products, supplies and devices developed and maintained by Kaiser Permanente. Generic drugs will be dispensed whenever available. Brand name drugs will be dispensed if there is not a generic equivalent. In the event you elect to purchase brand name drugs instead of the generic equivalent (if available), or if you elect to purchase a different brand name or generic drug than that prescribed by your Provider, and it is not determined to be Medically Necessary, you will also be subject to payment of the additional amount above the applicable pharmacy copayment. Mail order drugs and medicines dispensed through the Kaiser Permanente-designated mail order service are	Prescription drugs, medicines, supplies and devices for a supply of 30 days or less when listed in the Kaiser Permanente drug formulary are covered subject to the lesser of the plan's charge or **$20** for generic drugs or **$40** for brand name drugs or **50% up to $250 maximum** for non-preferred generic and brand name drugs; and **$0** for contraceptives and injectable vaccines. Note: An Enrollee will not pay more than $35 for a 30-day supply of insulin to comply with state law requirements. Injectables that can be self-administered are subject to the lesser of the plan's charge or the applicable prescription drug copayment (as set forth above). Covered injectables are subject to the lesser of the plan's charge or the applicable outpatient services copayment. Mail order drugs and medicines are covered as follows: • For a 30 days or less supply, subject to the lesser of the plan's charge or **$20** for generic drugs

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
covered for a supply of 90 days or less when listed in the Kaiser Permanente drug formulary. Excluded: over-the-counter drugs (including prescription drugs that have an over-the-counter equivalent), medicines, supplies and devices not requiring a prescription under state law or regulations; drugs used in the treatment of sexual dysfunction disorders; medicines and injections for anticipated illness while traveling; vitamins, including Legend (prescription) vitamins; drugs and injections for cosmetic purposes; any other drugs, medicines and injections not listed as covered in the Kaiser Permanente drug formulary unless approved in advance by Kaiser Permanente as Medically Necessary; compounds which include a non-FDA approved drug; growth hormones for idiopathic short stature without growth hormone deficiency. You will be charged for replacing lost or stolen drugs, medicines or devices. Injectables necessary for travel are not covered, and over-the-counter drugs and medicines are not covered.	or **$40** for brand name drugs or **50% up to $250 maximum** for non-preferred generic and brand name drugs • For a 31-90 day supply, subject to the lesser of the plan's charge or **$40** for generic drugs or **$80** for brand name drugs or **50% up to $750 maximum** for non-preferred generic and brand name drugs for up to a 90-day supply Note: An Enrollee will not pay more than $35 for a 30-day supply of insulin to comply with state law requirements
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).	**$30** per visit. **Note:** You pay **$0** for services provided in a CORF.
Outpatient substance abuse services† Covered services include: diagnostic evaluation, education, and organized individual and group counseling.	**$0**

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers† **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	**$200** per visit**.** **Note:** If outpatient surgery is performed in a doctor's office, the applicable office visit charge listed elsewhere in this chart will apply
Partial hospitalization services† "Partial hospitalization" is a structured program of active psychiatric treatment, provided as a hospital outpatient service or by a community mental health center that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	**$0**
Physician/practitioner services, including doctor's office visits Covered services include: • †Medically necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location. • †Consultation, diagnosis, and treatment by a specialist. • †Basic hearing and balance exams performed by a network provider, if your doctor orders it to see if you need medical treatment. • †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).	**Provider office visits** You pay the following depending upon the type of visit: • **$15** per primary care visit • **$30** per specialty care visit (except there's no charge for Medicare covered non routine dental care office visits). **†Outpatient surgery** • **$200** per visit.

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
• Certain telehealth services, including: primary and specialty care, which includes skilled nursing facility care, cardiac rehabilitation, urgently needed services, home health, physical, speech, and occupational therapies, mental health care, substance abuse treatment, dialysis services, kidney disease education, and diabetes self-management training, preparation for surgery or a hospital stay, and follow up visits after a hospital stay, surgery, or Emergency Department visit. Services will only be provided by telehealth when deemed clinically appropriate by the network provider rendering the service. ♦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. We offer the following means of telehealth: ○ 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: ♦ You have an in-person visit within 6 months prior to your first telehealth visit. ♦ You have an in-person visit every 12 months while receiving these telehealth services.	**$0**

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
♦ Exceptions can be made to the above for certain circumstances. • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers. • Virtual check-ins (for example, by phone or video chat) with your doctor for 5 to 10 minutes if: ♦ You're not a new patient And, ♦ The check-in isn't related to an office visit in the past 7 days and, ♦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment. • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: ♦ You're not a new patient And, ♦ The evaluation isn't related to an office visit in the past 7 days and, ♦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment. • Consultation your doctor has with other doctors by phone, internet, or electronic health record.	
Podiatry services† Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	**Office visits** • **$15** per primary care visit. • **$30** per specialty care visit **†Outpatient surgery** • **$200** per visit.
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.

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
Prosthetic devices and related supplies† Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery (see "Vision care" later in this section for more detail).	**20%** coinsurance
Pulmonary rehabilitation services† Comprehensive programs for pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**$20** per visit.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low-dose computed tomography (LDCT)† For qualified individuals, a LDCT is covered every 12 months. • Eligible members are people aged 50–77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

†Your provider must obtain prior authorization from our plan.

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

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

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
cover up to six sessions of kidney disease education services per lifetime.	
• 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). • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply).	**$0**
• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care).	No additional charge for services received during a hospital stay. Refer to the "Inpatient hospital care" section of this Medical Benefits Chart for the cost-sharing applicable to inpatient stays.
Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B drugs, please go to the section called "Medicare Part B prescription drugs."	
Skilled nursing facility (SNF) care† (For a definition of "skilled nursing facility care," see Chapter 10 of this document. Skilled nursing facilities are sometimes called "SNFs.") We cover up to 100 days per benefit period of skilled inpatient services in a skilled nursing facility in accord with Medicare guidelines (a prior hospital stay is not required). Covered services include, but are not limited to: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Skilled nursing services.	**$0** per benefit period. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or skilled nursing facility (SNF). The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 calendar days in a row.

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
• Physical therapy, occupational therapy, and speech therapy. • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood—including storage and administration. • Medical and surgical supplies ordinarily provided by SNFs. • Laboratory tests ordinarily provided by SNFs. • X-rays and other radiology services ordinarily provided by SNFs. • Use of appliances such as wheelchairs ordinarily provided by SNFs. • Physician/practitioner services. Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital.	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) **If you use tobacco, but do not have signs or symptoms of tobacco-related disease:** We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. **If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:** We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.	
Individual telephone-based Tobacco Cessation Program: Every time you enroll in this program, we provide up to 5, one-on-one counseling telephone calls with a Quit for Life Program staff member. An individual quit plan is developed with Quit for Life Program staff. Telephone support and materials are provided. Members can enroll in the program multiple times during the year to help them remain tobacco free.	**$0**
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. **Note:** SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time, if deemed medically necessary by a health care provider.	**$15** per primary care visit. **$30** per specialty care visit.
Transgender Services†	**Office visits** • **$15** per primary care visit.

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
Medically Necessary medical and surgical services for gender reassignment. Non-Emergency inpatient hospital services require Preauthorization.	• **$30** per specialty care visit **Outpatient surgery** • **$200** per visit. Cost-sharing is charged for each inpatient stay. • You pay **$200** per day for days **1–5** of a hospital stay. Thereafter there is **no charge** for the remainder of your covered hospital stay. Also, you do not pay the copayment listed above for the day you are discharged unless you are admitted and discharged on the same day.
Transportation services We cover up to six round trips, per calendar year, to get you to and from a network provider when provided by our designated transportation provider. Transportation provided by our network provider includes wheelchair vans, taxis, and other ground transportation as appropriate for your physical needs. To schedule a ride, call **1-877-828-4512** (TTY **711**) at least 2 days prior to your requested trip. To schedule a ride, call **1-877-828-4512** (TTY **711**) at least 2 days prior to your requested trip.	**$0** per round trips.

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
Urgently needed services Urgently needed services are provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are: i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. Services must be immediately needed and medically necessary. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider then your plan will cover the urgently needed services from a provider out-of-network. • **Inside our service area:** You must obtain urgent care from network providers, unless our provider network is temporarily unavailable or inaccessible due to an unusual and extraordinary circumstance (for example, major disaster). • **Outside our service area:** You have worldwide urgent care coverage when you travel if you need medical attention right away for an unforeseen illness or injury and you reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our service area.	**Urgent care facility** **$15** per primary care visit. **$30** per specialty care visit. Note: If you receive other services incident to an urgent care visit, you may be charged the applicable cost-sharing listed elsewhere in this Medical Benefits Chart for those services. **Emergency Department visits** **$65** 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. • Visual field tests. • Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. However, our plan does cover the following exams: ♦ One routine eye exam (eye refraction exam) per calendar year to determine the need for vision	• **$15** per optometry visit. • **$30** per ophthalmology visit

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
correction and to provide a prescription for eyeglass lenses.	
• †For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older. • For people with diabetes, screening for and monitoring of diabetic retinopathy.	**$0**
• One pair of eyeglasses or contact lenses (including fitting and dispensing) after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. • **Note**: You can get covered eyewear from in-network or from out-of-network providers. If you get eyewear out-of-network, you will need to pay for the eyewear and submit a claim to us and request reimbursement up to your allowance listed at right (see Chapter 7Section 2, for information about how to file a claim).	**$0** for eyewear in accord with Medicare guidelines. ***Note:** If the eyewear you purchase costs more than what Medicare covers, you pay the difference.
• **Other eyewear:** We provide a **$300** allowance every 24 months that you can use to pay for eyewear. The allowance can be used to pay for the following items: ♦ Eyeglass frames. ♦ Eyeglass lenses. ♦ Contact lenses, fitting, and dispensing. • We will not provide the allowance if we have provided an allowance toward (or otherwise covered) lenses or frames within the same 24-month period. • **Note**: You can get covered eyewear from in-network or from out-of-network providers. If you get eyewear out-of-network, you will need to pay for the eyewear and submit a claim to us and request reimbursement	*If the eyewear you purchase costs more than **$300**, **you pay the difference.**

†Your provider must obtain prior authorization from our plan.

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

Services that are covered for you	What you must pay when you get these services
up to your allowance listed at right (see Chapter 7Section 2, for information about how to file a claim).	
"Welcome to Medicare" preventive visit We cover the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.
Note: Refer to Chapter 1Section 7 and Chapter 9 for information about coordination of benefits that applies to all covered services described in this Medical Benefits Chart.	

Section 2.2 – Getting care using our visitor/traveler benefit

We offer as a supplemental benefit a visitor/traveler program in **Maricopa and Pima counties in Arizona**. This program is available to all Kaiser Permanente Medicare Advantage members who are temporarily in the visitor/traveler area. Under our visitor/traveler program, you may receive all plan covered services at in-network cost-sharing. Please contact Member Services (phone numbers are printed on the back cover of this document) for assistance in locating a provider when using the visitor/traveler benefit.

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

Section 3.1 – Services we do not cover (exclusions)

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

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

†Your provider must obtain prior authorization from our plan.

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

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered, and our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3, in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Care in an intermediate or residential care facility, assisted living facility, or adult foster home	√	
Conception by artificial means, such as in vitro fertilization, zygote intrafallopian transfers, ovum transplants, and gamete intrafallopian transfers (except artificial insemination and related services covered by Medicare)	√	
Cosmetic surgery or procedures		Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care • Custodial care is personal care that does not require the continuing attention	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.		
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance)		Covered if medically necessary and covered under Original Medicare.
Experimental medical and surgical procedures, equipment, and medications • Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		May be covered by Original Medicare under a Medicare-approved clinical research study. (See Chapter 3Section 5, for more information about clinical research studies.)
The following eyewear services and items: • Lens protection plan. • Nonprescription products. • Eyeglass or contact lens adornment.	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
• Eyewear items that do not require a prescription by law (other than eyeglass frames or a covered balance lens).		
Fees charged by your immediate relatives or members of your household.	√	
Full-time nursing care in your home	√	
Gender reassignment services	√ Cosmetic services including treatment for complications resulting from cosmetic surgery; complications of non-covered services	
Home-delivered meals	√	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation	√	
Licensed ambulance services without transport		Covered if the ambulance transports you or if covered by Medicare.
Nonconventional intraocular lenses (IOLs) following	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
cataract surgery (for example, a presbyopia-correcting IOL)		
Nonroutine dental care	• Injuries caused by biting or chewing; malocclusion resulting from an accidental injury. • Orthodontic treatment. • Dental implants. • Conditions not directly resulting from the accident. • Treatment not completed within the time period established in the written treatment.	√ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
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.
Outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas, and food	√	
Personal items in your room at a hospital or a skilled nursing facility such as a telephone or a television	√	
Physical exams and other services (1) required for obtaining		Covered if a network physician determines that the services are

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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		medically necessary or medically appropriate preventive care.
Private duty nursing	√	
Private room in a hospital		Covered when medically necessary.
Psychological testing for ability, aptitude, intelligence, or interest	√	
Radial keratotomy, LASIK surgery, and other low-vision aids	√	
Reconstructive surgery that offers only a minimal improvement in appearance or is performed to alter or reshape normal structures of the body in order to improve appearance		We cover reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defect, developmental abnormalities, accidental injury, trauma, infection, tumors, or disease, if a network physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible.
Reversal of sterilization procedures and non-prescription contraceptive supplies	√	
Routine dental care, such as cleanings, fillings or dentures	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Nonroutine dental care		Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Routine foot care		Some limited coverage provided according to Medicare guidelines (for example, if you have diabetes).
Services considered not reasonable and necessary, according to Original Medicare standards		This exclusion doesn't apply to services or items that aren't covered by Original Medicare but are covered by our plan.
Services provided to veterans in Veterans Affairs (VA) facilities		When emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our plan's cost-sharing amounts.
Services related to noncovered services or items		When a service or item is not covered, all services related to the noncovered service or item are excluded, (1) except for services or items we would otherwise cover to treat complications of the noncovered service or item, or (2) unless covered in accord with Medicare guidelines.
Services to reverse voluntary, surgically induced infertility	√	
Travel and lodging expenses		We may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines.

Chapter 5 — Asking us to pay our share of a bill you have received for covered medical services

Section 1 — Situations in which you should ask us to pay our share of the cost of your covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of our plan or you may receive a bill from a provider. In these cases, you can ask us to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

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

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

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

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

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

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

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

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

If you are retroactively enrolled in our plan

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

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

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this document has information about how to make an appeal.

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

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. You must submit your claim to us within 12 months of the date you received the service or item.

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

- Either download a copy of the form from our website (**kp.org**) or call Member Services and ask them to send you the form. Mail the completed form to our Claims Department address listed below.
- If you are unable to get the form, you can file your request for payment by sending us the following information to our Claims Department address listed below:
  - ♦ A statement with the following information:
  - o Your name (member/patient name) and medical/health record number.
  - o 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 and your medical record(s) for these services.

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

Kaiser Permanente
Claims Department
P.O. Box 30766
Salt Lake City, UT 84130-0766

Mail your request for payment for Medicare without Part D prescription claims together with any bills or receipts to us at this address:

OptumRX
PO Box 650334
Dallas, TX 75265-0334

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

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

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

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

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

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

the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7 of this document.

Chapter 6 — Your rights and responsibilities

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

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

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

Our plan has free interpreter services available to answer questions from non-English-speaking members. We can also give you information in large print or braille at no cost if you need it. We are required to give you information about our plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services.

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

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

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

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

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

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

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7 tells you what you can do.

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

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

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

How do we protect the privacy of your health information?

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

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

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

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

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

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

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

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

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers.**
  - You have the right to get information about the qualifications of the providers 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.
- **Information about why something is not covered and what you can do about it.**
  - Chapter 7 provides information on asking for a written explanation on why a medical service is not covered or if your coverage is restricted.
  - Chapter 7 also provides information on asking us to change a decision, also called an appeal.

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

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

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

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

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **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. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.

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

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

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

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

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

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

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Washington State Department of Health (call **1-360-236-4700**).

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

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document tells you what you can do. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—we are required to treat you fairly.

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

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

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

Is it about something else?

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

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

Section 1.8 – How to get more information about your rights

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

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

Section 1.9 – Information about new technology assessments

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

Section 1.10 – You can make suggestions about rights and responsibilities

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

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

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

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

- **If you move within your plan's service area**, we need to know so we can keep your membership record up-to-date and know how to contact you.
- **If you move outside of your plan's service area**, you cannot remain a member of our plan.
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

Chapter 7 — What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)

Section 1 — Introduction

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

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

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

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

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

Section 1.2 – What about the legal terms?

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

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

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

Section 2 — Where to get more information and personalized assistance

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

State Health Insurance Assistance Program (SHIP)

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

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

Medicare

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

- **Yes.**
  - ♦ Go on to the next section in this chapter, Section 4: "A guide to the basics of coverage decisions and appeals."
- **No.**
  - ♦ Skip ahead to Section 8 at the end of this chapter: "How to make a complaint about quality of care, waiting times, customer service, or other concerns."

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions prior to receiving services

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

Making an appeal

If we make a coverage decision, whether before or after a service is received, and you are not satisfied, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or "fast appeal" of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision. In limited circumstances, a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. (Appeals for medical services and Part B drugs will be automatically sent to the independent review organization for a Level 2 appeal—you do not need to do anything. If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

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

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

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

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

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

- **Section 5** in this chapter: "Your medical care: How to ask for a coverage decision or make an appeal."
- **Section 6** in this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon."

- **Section 7** in this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (applies only to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services).

If you're not sure which section you should be using, please call Member Services. You can also get help or information from government organizations such as your SHIP.

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

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

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this document: "Medical Benefits Chart (what is covered and what you pay)." To keep things simple, we generally refer to "medical care coverage" or "medical care," which includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Medicare Part B prescription drug. In those cases, we will explain how the rules for Medicare Part B prescription drugs are different from the rules for medical items and services.

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

- You are not getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 5.2**
- We will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 5.2**
- You have received medical care that you believe should be covered by our plan, but we have said we will not pay for this care. **Make an appeal. Section 5.3**
- You have received and paid for medical care that you believe should be covered by our plan, and you want to ask us to reimburse you for this care. **Send us the bill. Section 5.5.**
- You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 6 and 7 of this chapter. Special rules apply to these types of care.

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

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

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

A "standard coverage decision" is usually made within 14 days or 72 hours for Part B drugs. A "fast coverage decision" is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

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

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

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

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

For standard coverage decisions, we use the standard deadlines.

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

- However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should not take extra days, you can file a "fast complaint." We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 9 of this chapter for information on complaints.)

For fast coverage decisions, we use an expedited time frame.

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

- However, if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint". (See Section 9 this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

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

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

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

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

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

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal." If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 5.2 of this chapter.

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

- If you are asking for a standard appeal, submit your standard appeal in writing. Chapter 2 has contact information.

- If you are asking for a fast appeal, make your appeal in writing or call us. Chapter 2 has contact information.
- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

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

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a "fast appeal"

- For fast appeals, we must give you our answer **within 72 hours** after we receive your appeal. We will give you our answer sooner if your health requires us to.
  - ♦ However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
  - ♦ If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a "standard appeal"

- For standard appeals, we must give you our answer within 30 calendar days after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer within 7 calendar days after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
  - ♦ However, if you ask for more time, or if we need more information that may benefit you, we can take up to 14 more calendar days if your request is for a medical item or service.

If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- ♦ If you believe we should not take extra days, you can file a "fast complaint." When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 9 of this chapter for information on complaints.)
- ♦ If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.

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

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

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

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

Step 1: The independent review organization reviews your appeal.

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

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

- For the "fast appeal," the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, it can take up to 14 more calendar days. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

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

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

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

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 7 in this chapter explains the Level 3, 4, and 5 appeals processes.

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

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells you how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

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

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

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

To make this appeal, follow the process for appeals that we describe in Section 5.3. For appeals concerning reimbursement, **please note:**

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

Section 6 — How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury.

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

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

Section 6.1 – During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, you will be given a written notice called **An Important Message from Medicare about Your Rights.** Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Member Services or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week (TTY **1-877-486-2048**).

- **Read this notice carefully** and ask questions if you don't understand it. It tells you about:
  - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
  - Your right to be involved in any decisions about your hospital stay.
  - Where to report any concerns you have about the quality of your hospital care.
  - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.
- **You will be asked to sign the written notice** to show that you received it and understand your rights.
  - You or someone who is acting on your behalf will be asked to sign the notice.
  - Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.
- **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
  - If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
  - To look at a copy of this notice in advance, you can call Member Services or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. You can also see the notice online at **www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices**.

Section 6.2 – Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are:

- **Follow the process**.
- **Meet the deadlines**.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services. Or call your SHIP, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

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

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

How can you contact this organization?
The written notice you received **(An Important Message from Medicare About Your Rights)** tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly

- To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and **no later than midnight the day of your discharge**.
  - **If you meet this deadline,** you may stay in the hospital after your discharge date without paying for it while you wait to get the decision from the Quality Improvement Organization.
  - **If you do not meet this deadline,** and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

Once you request an immediate review of your hospital discharge, the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in

detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling Member Services or **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. (TTY users should call **1-877-486-2048**.) Or you can see a sample notice online at **www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices**.

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

Section 6.3 – Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

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

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

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

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

Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

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

If the review organization says yes:

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

If the review organization says no:

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 7 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 6.4 – What if you miss the deadline for making your Level 1 appeal?

Legal Term	A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, the first two levels of appeal are different.

Step-by-step: How to make a Level 1 alternate appeal

Step 1: Contact us and ask for a "fast review."

- **Ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines. Chapter 2 has contact information.

Step 2: We do a "fast review" of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will see if the decision about when you should leave the hospital was fair and followed all the rules.

Step 3: We give you our decision within 72 hours **after you ask for a "fast review."**

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
- **If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you received after the planned discharge date.**

Step 4: If we say no to your fast appeal, your case will automatically be sent on to the next level of the appeals process.

Step-by-step: Level 2 alternate appeal process

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

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

Step 1: We will automatically forward your case to the independent review organization. We are required to send the information for your Level 2 appeal to the independent review organization **within 24 hours** of when we tell you that we are saying **no** to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 8 in this chapter tells you how to make a complaint.)

Step 2: The independent review organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal**, then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue our plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal**, it means they agree that your planned hospital discharge date was medically appropriate.
    - The written notice you get from the independent review organization will tell how to start a Level 3 appeal with the review process, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say **no** to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- Section 7 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 7 — How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1 – This section is only about three services: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

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

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, **we will stop paying our share of the cost for your care.**

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

Section 7.2 – We will tell you in advance when your coverage will be ending

Legal Term	"**Notice of Medicare Non-Coverage**." It tells you how you can request a "**fast-track appeal**." Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:

- The date when we will stop covering the care for you.
- How to request a "fast track appeal" to request us to keep covering your care for a longer period of time.

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

Section 7.3 – Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services. Or call your SHIP, a government organization that provides personalized assistance.

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

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

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

How can you contact this organization?

- The written notice you received (**Notice of Medicare Non-Coverage**) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the **Notice of Medicare Non-Coverage**.

Your deadline for contacting this organization.

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

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

Legal Term	**"Detailed Explanation of Non-Coverage."** Notice that provides details on reasons for ending coverage.

What happens during this review?

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

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

What happens if the reviewers say yes?

- If the reviewers say yes to your appeal, then we must keep providing your covered services **for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

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

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

- If reviewers say no to your Level 1 appeal, and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 appeal.

Section 7.4 – Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

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

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

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

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

Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

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

What happens if the review organization says yes?

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

What happens if the review organization says no?

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

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 7 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 7.5 – What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal (within a day or two, at the most). If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

Step-by-step: How to make a Level 1 Alternate appeal

Legal Term	A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

Step 1: Contact us and ask for a "fast review."

- **Ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines. Chapter 2 has contact information.

Step 2: We do a "fast review" of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending our plan's coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a "fast review."

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end, **then you will have to pay the full cost of this care.**

Step 4: If we say no to your appeal, your case will automatically go on to the next level of the appeals process.

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

Step-by-step: Level 2 Alternate appeal process

During the Level 2 appeal, the independent review organization reviews the decision we made to your "fast appeal." This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization **within 24 hours** of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 9 of this chapter tells you how to make a complaint.)

Step 2: The independent review organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal**, then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal**, it means they agree with the decision our plan made to your first appeal and will not change it.
  - ♦ The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 8 — Taking your appeal to Level 3 and beyond

Section 8.1 – Appeal Levels 3, 4, and 5 for Medical Service Requests

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

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

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal: An Administrative Law Judge or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal it will go to a Level 4 appeal.
  - If we decide **not** to appeal, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal: The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the federal government.

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

whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal: A judge at the Federal District Court will review your appeal.

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

MAKING COMPLAINTS

Section 9 — How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 – What kinds of problems are handled by the complaint process?

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

- **Quality of your medical care**
  - Are you unhappy with the quality of care you have received (including care in the hospital)?
- **Respecting your privacy**
  - Did someone not respect your right to privacy or share confidential information?
- **Disrespect, poor customer service, or other negative behaviors**
  - Has someone been rude or disrespectful to you?
  - Are you unhappy with our Member Services?
  - Do you feel you are being encouraged to leave our plan?
- **Waiting times**
  - Are you having trouble getting an appointment, or waiting too long to get it?
  - Have you been kept waiting too long by doctors or other health professionals? Or by Member Services or other staff at our plan?
  - Examples include waiting too long on the phone, in the waiting or exam room.
- **Cleanliness**
  - Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
- **Information you get from our plan**
  - Did we fail to give you a required notice?
  - Is our written information hard to understand?

Timeliness (these types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)

If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples:

- You asked us for a "fast coverage decision" or a "fast appeal," and we have said no, you can make a complaint.
- You believe we are not meeting the deadlines for coverage decisions or appeals, you can make a complaint.
- You believe we are not meeting deadlines for covering or reimbursing you for certain medical services that were approved; you can make a complaint.
- You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 – How to make a complaint

Legal Terms	• A **"complaint"** is also called a **"grievance."** • **"Making a complaint"** is also called **"filing a grievance."** • "**Using the process for complaints**" is also called **"using the process for filing a grievance."** • A **"fast complaint"** is also called an **"expedited grievance."**

Section 9.3 – Step-by-step: Making a complaint

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

- **Usually calling Member Services is the first step**. If there is anything else you need to do, Member Services will let you know.
- **If you do not wish to call (or you called and were not satisfied),** you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to you in writing. We will also respond in writing when you make a complaint by phone if you request a written response or your complaint is related to quality of care.
- **If you have a complaint, we will try to resolve your complaint over the phone.** If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. Your grievance must explain your concern, such as why you are dissatisfied with the services you received. Please see Chapter 2 for whom you should contact if you have a complaint.
    - ♦ You must submit your grievance to us (orally or in writing) within 60 calendar days of the event or incident. We must address your grievance as quickly as your health requires, but no later than 30 calendar days after receiving your complaint. We may extend the time frame to make our decision by up to 14 calendar days if you ask for an extension, or if we justify a need for additional information and the delay is in your best interest.

- ♦ You can file a fast grievance about our decision not to expedite a coverage decision or appeal, or if we extend the time we need to make a decision about a coverage decision or appeal. We must respond to your fast grievance **within 24 hours**.
- The deadline for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

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

Section 9.4 – You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about quality of care, you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization**. The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.
- **Or you can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 9.5 – You can also tell Medicare about your complaint

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

Chapter 8 — Ending your membership in our plan

Section 1 — Introduction to ending your membership in our plan

Ending your membership in our plan may be voluntary (your own choice) or involuntary (not your own choice):

- You might leave our plan because you have decided that you want to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 5 in this chapter tells you about situations when we must end your membership.

If you are leaving our plan, we must continue to provide your medical care and you will continue to pay your cost share until your membership ends.

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

Section 2.1 – You can end your membership during the PEBB Retiree Employer Group Plan's annual enrollment period

You can end your membership in our plan during the PEBB Retiree Employer Group's annual enrollment period (also known as the "annual open enrollment period"). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **Contact your employer group for the annual enrollment period**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year**. If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan with or without prescription drug coverage.
  - Original Medicare **with** a separate Medicare prescription drug plan.
  - Original Medicare without a separate Medicare prescription drug plan.
- **Your membership will end in our plan** when your new plan's coverage begins.

Section 2.2 – You can end your membership during the Medicare Advantage open enrollment period

You have the opportunity to make **one** change to your health coverage during the **Medicare Advantage open enrollment period.**

- **The annual Medicare Advantage open enrollment period** is from January 1 to March 31.
- **During the annual Medicare Advantage open enrollment period**, you can:
  - Switch to another Medicare Advantage plan with or without prescription drug coverage.

- Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.

- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3 – In certain situations, you can end your membership during a special enrollment period

In certain situations, members of our plan may be eligible to end their membership at other times of the year. This is known as a special enrollment period.

- **You may be eligible to end your membership during a special enrollment period** if any of the following situations apply to you. These are just examples; for the full list, you can contact our plan, call Medicare, or visit the Medicare website (**www.medicare.gov**):
  - Usually, when you have moved.
  - If you end your enrollment in the PEBB Retiree Plan.
  - If you have Medicaid.
  - If we violate our contract with you.
  - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
  - If you enroll in the Program of All-Inclusive Care for the Elderly (PACE).
- **The enrollment time periods vary** depending upon your situation.
- **To find out if you are eligible for a special enrollment period**, please call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:
  - Another Medicare health plan with or without prescription drug coverage.
  - Original Medicare **with** a separate Medicare prescription drug plan.
  - Or Original Medicare **without** a separate Medicare prescription drug plan.

Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.4 – Where can you get more information about when you can end your membership?

If you have any questions about ending your membership, you can:

- **Call Member Services**.
- Find the information in the **Medicare & You** 2023 handbook.

- Contact Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week (TTY **1-877-486-2048**).

Section 3 — How do you end your membership in our plan?

You end your membership in our plan through your employer. Contact your employer for more information. **Note**: If you also have creditable prescription drug coverage (e.g., standalone PDP) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable prescription drug coverage for 63 days or more in a row.

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

Until your membership ends, and your new Medicare coverage begins, you must continue to get your medical care through our plan.

- Continue to use our network providers to receive medical care.
- If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).

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

Section 5.1 – When must we end your membership in our plan?

We must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - ♦ If you move or take a long trip, call Member Services to find out if the place you are moving or traveling to is in our plan's area.
  - ♦ If you have been a member of our plan continuously prior to January 1999, and you were living outside of our service area before January 1999, you are still eligible as long as you have not moved since before January 1999. However, if you move and your move is to another location that is outside of our service area, you will be disenrolled from our plan.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If plan premiums are not paid for you.
- If you are no longer eligible for coverage under your employer group plan.
- If your employer group terminates your plan with us.
- If you let someone else use your membership card to get medical care. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
    - ♦ If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

If you have questions or would like more information about when we can end your membership, call Member Services.

Section 5.2 – We cannot ask you to leave our plan for any health-related reason

We are not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at **1-800-MEDICARE (1-800-633-4227)** 24 hours a day, 7 days a week. (TTY **1-877-486-2048**).

Section 5.3 – You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

Chapter 9 — Legal notices

Section 1 — Notice about governing law

The principal law that applies to this **Evidence of Coverage** document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

Section 2 — Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at **1-800-368-1019** (TTY **1-800-537-7697**) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at **https://www.hhs.gov/ocr/index**.

If you have a disability and need help with access to care, please call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Section 3 — Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Kaiser Permanente Medicare Advantage, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

Section 4 — Administration of this Evidence of Coverage

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this **Evidence of Coverage**.

Section 5 — Applications and statements

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

Section 6 — Assignment

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

Section 7 — Attorney and advocate fees and expenses

In any dispute between a member and Health Plan, Medical Group, or plan hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses, except as otherwise required by law.

Section 8 — Coordination of benefits

As described in Chapter 1Section 7 "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 Kaiser Permanente Medicare Advantage PEBB Retiree Employer Group 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 16 in this chapter, and for primary payments in workers' compensation cases, see Section 18 in this chapter.

You must tell us if you have other health care coverage, and let us know whenever there are any changes in your additional coverage.

Section 9 — Employer responsibility

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

Section 10 — Evidence of Coverage binding on members

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

Section 11 — Government agency responsibility

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

Section 12 — Member nonliability

Our contracts with network providers provide that you are not liable for any amounts we owe. However, you are liable for the cost of noncovered services you obtain from network providers or out-of-network providers.

Section 13 — No waiver

Our failure to enforce any provision of this **Evidence of Coverage** will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Section 14 — Notices

Our notices to you will be sent to the most recent address we have. You are responsible for notifying us of any change in your address. If you move, please call Member Services (phone numbers are printed on the back of this document) and Social Security at **1-800-772-1213** (TTY **1-800-325-0778**) as soon as possible to report your address change.

Section 15 — Overpayment recovery

We may recover any overpayment we make for services from anyone who receives such an overpayment or from any person or organization obligated to pay for the services.

Section 16 — Third party liability

As stated in Chapter 1Section 7, 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:

Kaiser Permanente
Other Party Liability
P.O. Box 210
Spokane, WA 99210

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

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

Section 17 — U.S. Department of Veterans Affairs

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

Section 18 — Workers' compensation or employer's liability benefits

As stated in Chapter 1Section 7, 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.

Chapter 10 — Definitions of important words

Allowance – A specified credit amount that you can use toward the cost of an item. If the cost of the item(s) you select exceeds the allowance, you will pay the amount in excess of the allowance, which does not apply to the maximum out-of-pocket amount.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Annual Open Enrollment- A period of time defined by HCA when a Subscriber may change to another health plan offered by the PEBB Program and make certain other account changes for an effective date beginning January 1 of the following year.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measure your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

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.

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used only for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive 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.

Continuation Coverage- Temporary continuation of PEBB benefits available to Enrollees under the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Uniformed Services Employment and Reemployment Rights Act (USERRA), or PEBB policies.

Coordination of Benefits (COB) – Coordination of Benefits is a provision used to establish the order in which claims are paid when you have other insurance. If you have Medicare and other health insurance or coverage, each type of coverage is called a "payer." When there is more than one payer, there are "coordination of benefits" rules that decide which one pays first. The "primary payer" pays what it owes on your bills first, and then sends the rest to the "secondary payer" to pay. If payment owed to us is sent directly to you, you are required under Medicare law to give the payment to us. In some cases, there may also be a third payer. See Chapter 1Section 7 and Chapter 9Section 8 for more information.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. 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 are received. (This is in addition to our plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed "copayment" amount that a plan requires when a specific service is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service that a plan requires when a specific service or drug is received. **Note:** In some cases, you may not pay all applicable cost-sharing at the time you receive the services, and we will send you a bill later for the cost-sharing. For example, if you receive nonpreventive care during a scheduled preventive care visit, we may bill you later for the cost-sharing applicable to the nonpreventive care. For items ordered in advance, you pay the cost-sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the cost-sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription.

Covered Services – The term we use to mean all of the health care services and items that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Deductible – The amount you must pay for health care before our plan pays.

Disenroll or Disenrollment – The process of ending your membership in our plan.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include: walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech-generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

Emergency Care – Covered services that are (1) provided by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Emergency Medical Condition – A medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Enrollee- 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).

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.

Grievance – A type of complaint you make about our plan or providers, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

Health Care Authority (HCA)- The Washington State agency that administers the PEBB and SEBB Programs.

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (for example, bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Medical Benefits Chart in Chapter 4, Section 2. We cover home health care in accord with Medicare guidelines. Home health care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services do not include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

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

Inpatient Hospital Care – Health care that you get during an inpatient stay in an acute care general hospital.

Kaiser Foundation Health Plan (Health Plan) – Kaiser Foundation Health Plan of Washington, is a nonprofit corporation and a Medicare Advantage organization. This **Evidence of Coverage** sometimes refers to Health Plan as "we" or "us."

Kaiser Permanente – Health Plan and Medical Group.

Kaiser Permanente Region (Region) – A Kaiser Foundation Health Plan organization that conducts a direct-service health care program. When you are outside our service area, you can get medically necessary health care and ongoing care for chronic conditions from designated providers in another Kaiser Permanente Region's service area. For more information, please refer to Chapter 3, Section 2.4.

Long-Term Care Hospital – A Medicare-certified acute-care hospital that typically provide Medicare covered services such as comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. They are not long-term care facilities such as convalescent or assisted living facilities.

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 your plan premiums and Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary

from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medical Care or Services – Health care services or items. Some examples of health care items include durable medical equipment, eyeglasses, and drugs covered by Medicare Part A or Part B.

Medical Group – It is the network of plan providers that our plan contracts with to provide covered services to you. The name of our medical group is the Washington Permanente Medical Group, a for-profit professional corporation.

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 Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

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 of the services that are covered by Medicare Part A and B. The term "Medicare-covered services" does not include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/ Pilot Programs, and Programs of All-Inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network Physician – Any licensed physician who is a partner or 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."

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. You must voluntarily elect optional supplemental benefits in order to get them.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this document.

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

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for "Cost-Sharing" above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's "out-of-pocket" cost requirement.

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) for as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – See **"Medicare Advantage (MA) Plan."**

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Plan – Kaiser Permanente Medicare Advantage PEBB Retiree Employer Group Plan.

Plan Charges – Plan Charges means the following:

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

Post-Stabilization Care – Medically necessary services related to your emergency medical condition that you receive after your treating physician determines that this condition is clinically stable. You are considered clinically stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (nonpreferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health care or prescription drug coverage.

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4 and described in Chapter 3, Section 2.3.

Prosthetics and Orthotics – Medical devices including, but are not limited to: arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy and urological supplies and enteral and parenteral nutrition therapy.

Public Employees Benefits Board (PEBB)- A group of representatives, appointed by the governor, who approves insurance benefit plans for employees and their dependents, and establishes eligibility criteria for participation in insurance benefit plans.

Public Employees Benefits Board (PEBB) Program- Is the HCA program that administers PEBB benefit eligibility and enrollment.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

School Employees Benefits Board (SEBB)- A group of representatives, appointed by the governor, who designs and approves insurance benefit plans for school employees and their dependents, and establishes eligibility criteria for participation in insurance benefit plans.

School Employees Benefits Board (SEBB) Organization- A public school district or educational service district or charter school established under Washington state statute that is required to participate in benefit plans provided by the School Employees Benefits Board (SEBB).

School Employees Benefits Board (SEBB) Program- Is the program within HCA that administers insurance and other benefits for eligible school employees and eligible dependents.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (nonemergency) services. Our plan must disenroll you if you permanently move out of your plan's service area.

Services – Health care services or items.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a special enrollment period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Subscriber – A member who has been determined eligible for membership on their own behalf and not by virtue of dependent status, is enrolled in this plan, and is the individual to whom the PEBB Program or this Plan will issue notices, information, requests, and premium bills on behalf of an Enrollee.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

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Kaiser Permanente Medicare Advantage Basic Member Services

METHOD	Member Services—contact information
CALL	**1-888-901-4600** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Kaiser Permanente Member Services P.O. Box 34590 Seattle, WA 98124 E-mail: **kp.org** and click on "Contact Us"
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.

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