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KAISER PERMANENTE®

October 21, 2025

COURTNEY WAITE, VICE PRESIDENT, TOTAL REWARDS
AFFIRM INC
650 CALIFORNIA ST FL 12
SAN FRANCISCO, CA 94108-2716

Re: Renewal *Group Agreement* for Group ID # 235801
Renewal effective date: 01/01/2026

Dear COURTNEY WAITE,

We value being your health care partner, and look forward to continuing to work with you to provide your subscribers with quality care well into the future.

Enclosed, please find the new *Group Agreement* between AFFIRM INC and Kaiser Foundation Health Plan, Inc., Southern California Region, for the contract period January 1, 2026, through December 31, 2026. For a summary of the most important changes, see the enclosed 2026 *Notice*. Review these documents carefully and keep the *Group Agreement* for your records. Also, be sure to sign and return the copy of the *Agreement* Signature Page provided with the *Group Agreement*.

If your group doesn't want to renew the *Group Agreement*, you'll need to give us advance written notice, as described under "Termination on Notice" in the "Termination of Agreement" section of your *Group Agreement*.

You should have already received the *Disclosure Form* and a *Summary of Benefits and Coverage.* These documents include information to help your employees make the right plan choice for their needs.

Please note: We require subscribers to agree to the use of binding arbitration to settle disputes when they enroll. In turn, your group must show that each subscriber has agreed. We have tools that can help. For details, see the *Administrative Handbook* on our website at **business.kp.org**. Kaiser Permanente's arbitration agreement with members is described in the *EOC.*

If you have any questions or need enrollment or enrollee materials for your subscribers, please contact your Kaiser Permanente account manager, Autumn Oraiqat, at 510-641-8109.

If you receive the *Group Agreement* or enrollment materials in electronic form, you are not authorized to modify or alter in any way the text or the formatting of these documents. If you post the electronic documents on your intranet site, you must do so in such a way so as to permit your subscribers to download and print a complete and accurate copy of the materials. Please refer to the *Group Agreement* for details about these requirements.

Thank you for continuing to offer Kaiser Permanente to your subscribers.

Sincerely,

Thomas A. Curtin Jr.
Senior Vice President, Commercial Group Business

cc:

BARBARA CADIGAN
DAVID A FISHER

Agreement Signature Page

Acceptance of *Agreement*

Group acknowledges acceptance of this *Agreement* by signing the Signature Page and returning it to Health Plan. If Group does not return it to Health Plan, Group will be deemed as having accepted this *Agreement* if Group pays Health Plan any amount toward Premiums.

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

Binding Arbitration

As more fully set forth in the arbitration provision in the applicable *Evidence of Coverage*, disputes between Members, their heirs, relatives, or associated parties (on the one hand) and Health Plan, Kaiser Permanente health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising out of or related to this *Agreement*, including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this *Agreement*, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. Members enrolled under this *Agreement* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the applicable *Evidence of Coverage* except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

Signatures

Kaiser Foundation Health Plan, Inc., Southern California Region



Thomas A. Curtin Jr.
Authorized officer
Senior Vice President, Commercial Group Business
October 21, 2025

AFFIRM INC

Authorized Group officer signature

Print name and title Date

Please sign and return this copy of the signature page:

- **By mail:** Kaiser Permanente, California Service Center, P.O. Box 23448, San Diego, CA 92193-3448.
- **By fax:** 1-855-355-5334

Helpful information about disclosures that Group must make

The Group is required to provide certain disclosures about its group health plan to employees and dependents:

- As described in your *Group Agreement*, Group must notify subscribers and dependents about changes to coverage and provide an *Evidence of Coverage (EOC)*.
- If Group's group health plan is subject to Affordable Care Act (ACA) mandates, Group must provide any required ACA notices.
- If Group's group health plan is subject to ERISA, Group's plan administrator must provide a Summary Plan Description. In addition, Groups may have additional reporting and disclosure obligations under ERISA. These additional requirements are the Group's responsibility. For more information on your group health plan's obligations under ERISA, we recommend that you seek the advice of your own legal counsel. You may also find general information at **dol.gov/agencies/ebsa**. A handy Reporting and Disclosure Guide for Employee Benefit Plans is also available on that website.

In addition, the *EOCs* that are part of your *Group Agreement* provide certain notices as described in this document. The information in this document applies to commercial group coverage offered by Health Plan in its Northern and Southern California Regions (it does not apply to Medicare coverage, the Federal Employees Health Benefit Plan, or self-funded coverage). This document is not legal advice. Group should consult its own legal counsel for specific guidance related to its group health plan requirements.

Disclosures required by the ACA

The *EOCs* include the following notices required by the ACA:

- **Grandfathered status:** In *EOCs* for grandfathered coverage, a notice of grandfathered status is provided in the "Cost Share Summary" section.
- **Choice of provider.** A notice about designating a Plan Primary Care Physician (including a pediatrician for a child) is provided under "Your Personal Plan Physician" in the "How to Obtain Services" section.
- **Access to Plan obstetricians and gynecologists.** A notice that prior authorization is not required to receive care from obstetricians and gynecologists is provided under "Getting a Referral" in the "How to Obtain Services" section.
- **Claims procedure.** The procedure for post-service claims is explained in the "Post-Service Claims and Appeals" section. The procedure for all other requests for payment and services is explained in the "Dispute Resolution" section. The "Dispute Resolution" section says that binding arbitration is not required when governing law prevents the use of binding arbitration.
- **Nondiscrimination.** A nondiscrimination notice and language assistance taglines are provided with the *EOC*.

SPD Disclosures required by ERISA

The Employee Retirement Income Security Act (ERISA) is a federal law that sets minimum standards for employee welfare benefit plans, which includes group health plans, and is established by private employers and employee organizations (for example, unions). The plan administrator of an employee welfare benefit plan is responsible for development and distribution of a *Summary Plan Description (SPD)* to plan participants and beneficiaries. The plan administrator is an employee or designee of the employer or union plan sponsor. Health Plan underwrites group coverage that plan sponsors make available, but Health Plan is neither the "ERISA plan" nor the "plan administrator" of the group health plan.

The plan administrator of a group health plan may satisfy the Group's ERISA disclosure obligations by incorporating the *EOC* into the Group's *SPD by reference*. However, the *EOC* by itself does not satisfy the disclosure requirements under ERISA. If a disclosure required under ERISA is not in the *EOC*, or if the plan administrator chooses to not incorporate the *EOC* in the *SPD*, the plan administrator must provide the disclosure in the Group's *SPD*. If there are discrepancies between

the description of Kaiser Permanente HMO-covered group health plan benefits appearing in the Group's *SPD* and those reflected in the *EOC,* the benefit description appearing in Kaiser Permanente's *EOC* will control.

The chart below identifies certain key ERISA disclosure requirements and whether those disclosures are in the *EOC*. It is intended for use as a reference tool; however, it is the plan administrator's responsibility to verify that the Group's *SPD* satisfies all ERISA disclosure requirements. For more information about ERISA, visit the Department of Labor website at **dol.gov/agencies/ebsa**.

SPD Disclosure Requirement	Evidence of Coverage (EOC)
Eligibility	The *EOC* does not explain in detail Group's eligibility requirements (a summary of Health Plan eligibility requirements appears in the "Premiums, Eligibility, and Enrollment" section). The plan administrator must include Group's specific eligibility information in the Group's *SPD*.
Special enrollment, including: • Special enrollment due to new dependents • Special enrollment due to loss of other coverage • Special enrollment due to eligibility for premium assistance • Special enrollment due to court or administrative order • Special enrollment due to reemployment after military service • Other special enrollment events	The *EOC* explains special enrollment rights in "How to Enroll and When Coverage Begins" in the "Premiums, Eligibility and Enrollment" section. The plan administrator is required to document that plan participants and beneficiaries have been informed of these rights. The *EOC* does not describe the procedures governing qualified medical child support order (QMCSO) determinations or state that plan participants and beneficiaries can obtain, without charge, a copy of those procedures from the plan administrator. The plan administrator should include this information in the Group's *SPD*.
Michelle's law (student status and eligibility)	Michelle's law establishes that dependent children who are under the dependent child age limit of the group health plan eligibility rules meet the eligibility age requirement whether or not they are attending school. Therefore, Health Plan provides a notice about student leaves of absence only in *EOCs* where the dependent child age limit is higher for a student than the non-student. If the student age limit is higher, the notice appears in the "Who Is Eligible" section under "Eligibility as a Dependent."

SPD Disclosure Requirement	Evidence of Coverage (EOC)
Description of coverage, including: • Cost sharing • Exclusions and limitations • Prior authorization requirements • Provider network • Claims procedure	Under ERISA, a Group's *SPD* may provide only a general description of plan benefits as long as the *SPD* references a detailed schedule of benefits and incorporates it by reference. That detailed schedule of benefits can be the Health Plan *EOC*, which offers a clear description of the benefits and the rules for obtaining those benefits. If the plan administrator chooses to incorporate the *EOC* by reference into the Group's *SPD*, the Group may satisfy the ERISA coverage disclosure requirements by including the following text *without changes* as the introduction to the benefit chart in the Group's *SPD*: "This benefit chart provides summary information only. It does not fully describe your benefit coverage. For details on your benefit coverage, please refer to your Kaiser Foundation Health Plan, Inc. (Health Plan) *Evidence of Coverage*. The Health Plan *Evidence of Coverage* is the binding document between Health Plan and its members. As a condition of coverage, a Health Plan physician must determine that any requested services and items are medically necessary to prevent, diagnose, or treat a medical condition. Generally, requested services and items must be provided, prescribed, authorized, or directed by a Health Plan provider. Except as otherwise noted in the Health Plan *Evidence of Coverage*, you must receive the requested services and items from a Health Plan-designated provider inside the Health Plan Service Area in which you are enrolled. For details on the benefit and claims review and adjudication procedures, please refer to the Health Plan *Evidence of Coverage.*"
Newborns' and Mothers' Health Protection Act (Newborn Act)	Health Plan covers hospital lengths of stay following childbirth for mothers and newborns in accord with the Newborn Act. To assist the plan administrator in complying with the ERISA notice requirement, a Newborn Act notice is included under "ERISA notices" in the "Miscellaneous Provisions" section of the *EOC*.
Women's Health and Cancer Rights Act (WHCRA)	Health Plan covers mastectomy and reconstructive surgery and related services as required by WHCRA. To assist the plan administrator in complying with the ERISA notice requirement, a WHCRA notice is included under "ERISA notices" in the "Miscellaneous Provisions" section of the *EOC*.
ERISA rights	The *EOC* does not include a statement of ERISA rights. The plan administrator should include this information in the Group's *SPD*.
COBRA	The *EOC* states that continuation health care coverage under federal COBRA or under state continuation coverage laws may be available following termination of group health coverage. If your employee benefit plan offers COBRA continuation coverage, your plan administrator is responsible for administration of this coverage (for example, your plan administrator is responsible for providing all notices related to continuation coverage, eligibility, and participation).

SPD Disclosure Requirement	Evidence of Coverage (EOC)
Information about the employee benefit plan and how it is administered, such as: • Name of the plan • Name and address of the entity maintaining the plan • Employer identification number, plan number, type of plan, and how it is administered • The plan administrator's authority to terminate the plan or amend benefits, circumstances that may trigger ineligibility, denial, or reduction of benefits, and rights upon termination of plan or amendment of benefits	Health Plan does not collect this information from groups and cannot include it in the *EOC.* The plan administrator must include this information in the Group's *SPD*.

2026 *Group Agreement* Summary of Changes and Clarifications Notice Effective January 1, 2026, through December 31, 2026

Kaiser Foundation Health Plan, Inc., Southern California Region ("Health Plan") is renewing your Group's *Group Agreement ("Agreement")*, including the *Evidence of Coverage ("EOC")* documents, effective January 1, 2026 (your Group's "Anniversary Date") by sending AFFIRM INC ("Group") this *"Group Agreement Summary of Changes and Clarifications Notice" ("Notice")* in accord with the "Term of *Agreement* and Renewal" section of your *Agreement*. This *Notice* includes a summary of the changes and clarifications that will be effective when your *Agreement* is renewed on the Anniversary Date, unless a different effective date is stated. Unless otherwise indicated, the changes and clarifications described here apply to each type of coverage that will be effective upon renewal of your *Agreement*. If you have not already received your renewal contract ("*2026 Agreement*"), please contact your broker or Health Plan account manager to obtain a copy. If your Group does not wish to renew your *Agreement*, your Group must give us advance written notice in accord with "Termination on Notice" in the "Termination of *Agreement*" section of your *Agreement*.

In certain circumstances, this summary may also include changes that we made to your *Agreement* during the 2025 plan year through an amendment. This summary does not include minor changes and clarifications that Health Plan is making to improve the readability of the *Agreement* or any changes we are making at your Group's request. In addition to the changes and clarifications listed below, Health Plan will also make any changes required by law or by any state or federal agency.

The "Calculating Premiums" section of this *Notice* includes the Premiums that will be applicable to your *Agreement* upon renewal.

Note: Some capitalized terms in this *Notice* have special meaning. Please see the "Definitions" section of the applicable *EOC* document in your *Agreement* for terms you should know. In this *Notice* "Medicare *EOCs*" means Kaiser Permanente Senior Advantage *EOCs*, and "non-Medicare *EOCs*" means all *EOCs* other than Senior Advantage *EOCs.*

2026 Agreement

If you have not already received your *2026 Agreement* and your Group wants to make changes to benefits or Cost Share, please request them before your Anniversary Date. You will then receive your *2026 Agreement* shortly after you tell your Health Plan account manager about changes your Group wants to make. If you don't wish to make changes to benefits or Cost Share, you don't need to do anything to renew your *Agreement*. We will provide your Group with its *2026 Agreement* within 60 days after your Anniversary Date. If you would like to receive it sooner, please contact your Health Plan account manager.

We will provide the *2026 Agreement* to your Group online in the Documents section of **business.kp.org**. If your Group would like a paper copy of your *2026 Agreement* and you are not able to download it from **business.kp.org**, please contact our customer service team at **800-731-4661**.

Please keep in mind that unless your Group notifies us to make changes to benefits or Cost Share, your *2026 Agreement*, including the *EOC* documents, will reflect the same benefits and Cost Share information as your current *Agreement,* subject to the changes described in this *Notice*.

Revisions to 2026 Kaiser Permanente *EOCs*

The changes and clarifications to *Evidence of Coverage* ("*EOC*") documents described below are effective on your Group's Anniversary Date (unless a different effective date is stated).

Note: Some capitalized terms in this *Notice* have special meaning. Please see the "Definitions" section of the applicable *EOC* for terms you should know. In this *Notice* "Medicare *EOCs*" means Kaiser Permanente Senior Advantage *EOCs*, and "non-Medicare *EOCs*" means all *EOCs* other than Senior Advantage *EOCs*.

Changes

Claims Payment (SB 3275)

***In accordance with state law**, we have updated information related to claims timeframes under "Initial Claims" in the "Post-Service Claims and Appeals" section of non-Medicare EOCs.*

Drugs prescribed to treat PANS/PANDAS (AB 2105)

***In accordance with state law effective January 1, 2025**, Cost Share for drugs prescribed to treat Pediatric Acute-Onset Neuropsychiatric Syndrome and Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections ("PANS/PANDAS") cannot be subject to a Cost Share greater than that applies to other benefits provided in the contract. For most plans, there is no impact to coverage or Cost Share for these drugs. Outpatient prescription drugs prescribed to treat PANS/PANDAS are covered as described in the "Most drugs" table under "Outpatient Pharmacy Services" in the Cost Share Summary in non-Medicare EOCs. However, in benefit plans where the "Most drugs" table says "Not covered," outpatient prescription drugs prescribed to treat PANS/PANDAS are now covered as described in the "Other state-mandated drugs" row in the "Certain state-mandated drugs" table under "Outpatient Pharmacy Services" in the Cost Share Summary.*

Fertility preservation Services (SB 600)

***In accordance with state law**, in contracts issued, amended, or renewed on or after July 1, 2025, the "Fertility Preservation Services for Iatrogenic Infertility" section of non-Medicare EOCs includes coverage for Standard Fertility Preservation Services.*

Fertility Services (SB 729)

***In accordance with state law**, the "Fertility Services" and "Outpatient Pharmacy Services" sections of non-Medicare EOCs include coverage of the following services:*

- *Services required to diagnose infertility, including laboratory and imaging services*
- *Services to treat infertility, including medications, artificial insemination, and in vitro fertilization*

Coverage includes up to three oocyte retrievals per lifetime.

Under SB 729, cost share for fertility services must be the same as the cost share for those services when provided for non-fertility related conditions.

Certain religious employer groups may be exempt from providing fertility services coverage.

Health care treatment following rape or sexual assault (AB 2843)

***In accordance with state law effective July 1, 2025**, at the end of the Cost Share Summary in non-Medicare EOCs, we have added a new section titled "Health Care Treatment Following Rape or Sexual Assault," explaining that the following services related to rape or sexual assault are covered at no charge (subject to the deductible in HDHP plans only):*

- *Emergency Services related to the rape or sexual assault that are received from Plan Providers or Non-Plan Providers*
- *Related follow-up Services that are received from Plan Providers*

Human milk (AB 3059)

***In accordance with state law effective January 1, 2025**, under "Outpatient Pharmacy Services" in the "Benefits" section of non-Medicare EOCs, we have added a new section describing coverage of medically necessary pasteurized human milk:*

> We cover medically necessary pasteurized human milk when prescribed by a Plan Provider and obtained from a designated licensed tissue bank. The day supply dispensed may vary based on availability. You may have to pay for the human milk and file a claim for reimbursement. For information on how to file a claim, please see "Initial Claims" in the "Post-Service Claims and Appeals" section.

Medicare Part D Outpatient Prescription Drug Coverage

- *The Senior Advantage Medicare Part D Catastrophic Coverage Stage threshold is increasing from $2,000 to $2,100 for calendar year 2026, in accordance with the Centers for Medicare & Medicaid Services (CMS) requirements.*
- *If a member requests and we agree to cover a Part D brand-name drug that is not on our Drug List, the Cost Share amount will vary depending on your plan. Members cannot ask for an exception to the Copayment or Coinsurance amount we require them to pay for the drug.*

Clarifications

988 crisis line

Under "Emergency Services" in the "How to Obtain Services" section of non-Medicare *EOCs*, we have added a sentence explaining that members may call 988 to be connected to a trained crisis counselor if they are experiencing a mental health crisis. 911 services also remain available in any emergency.

Administered COVID-19 therapeutics

In the "Administered drugs and products" table in the Cost Share Summary in non-Medicare *EOCs*, we have added rows for administered COVID-19 therapeutics from Plan Providers and Non-Plan Providers (such as monoclonal antibodies). This is a clarification, not a change in coverage.

Age limit of Dependent children

Under "Age limit of Dependent children" in large group non-Medicare *EOCs* and grandfathered small group non-Medicare *EOCs*, we have deleted language indicating that children placed with a Subscriber or Spouse for foster care are not eligible for Dependent coverage under certain circumstances. Health Plan allows enrollment of foster children as Dependents if the Subscriber or their Spouse has the legal authority to direct their care. This is not a change in policy, just a clarification in the *EOC*.

CMS EOC language

The Medicare *EOC* language has been revised throughout to align with the CMS EOC model. This does not represent a change in coverage.

Completion of Services

Under "Completion of Services from Non-Plan Providers" in non-Medicare *EOCs*, we have clarified that a new Member must have been covered under another health plan when services of the Non-Plan Provider ended in order to qualify for completion of services from that provider. This is not a change in policy, just a clarification in the *EOC*.

Cross references

We have made several updates to cross-references in non-Medicare *EOCs*:

- Under "Administered Drugs and Products" in the "Benefits" section, we have clarified that all preventive administered drugs except for contraceptives are covered as described in the "Preventive Services" section. Additionally, we have revised the format of the existing cross references for consistency with other sections of the *EOC.*
- We have added new cross references under "Mental Health Services," "Office Visits," "Outpatient Pharmacy Services," "Rehabilitative and Habilitative Services," and "Substance Use Disorder Treatment" to make it easier to identify which benefit category applies to certain services.

These revisions are editorial only and do not represent a change in policy.

DMHC-required *EOC* language (AB 118)

Under "Definitions," "Exclusions," and "Miscellaneous Provisions," we have revised non-Medicare *EOC* language as required by the California Department of Managed Health Care. Due to state law, health plans are required to use these new defined terms, exclusions, and information about Member rights and responsibilities in their *EOCs*. We have also revised some other provisions to accommodate the mandated terminology:

- The "Outpatient Prescription Drugs, Supplies, and Supplements" section is now called "Outpatient Pharmacy Services"

- The exclusion for Services related to noncovered Services is now described under "Noncovered Services" in the "Your Cost Share" section
- Certain general exclusions and all exclusions within the "Benefits" section have been reformatted to be part of the description of the scope of coverage

Doula Services

Under "Plan Doula Services" in the "Reproductive Health Services" section of non-Medicare *EOCs*, we have clarified the services that are not covered as Plan Doula services and added a reference to **kp.org/doulacare**, which members can visit for information about how to find a doula. This is not a change in coverage, just a clarification in the *EOC*.

Emergency Services and Urgent Care

We have deleted the standalone "Emergency Services and Urgent Care" section of non-Medicare *EOCs* in its entirety, to reduce repetition in the *EOC* and make it easier to find information about these Services. Most of the deleted section was moved to the "How to Obtain Services" section, but details about Cost Share for emergency services and urgent care have been moved to "Emergency Services and Urgent Care" in the "Benefits" section of the *EOC*. These changes are editorial only and there are no changes to coverage or policies.

Gender-affirming Services

Under "Gender-affirming Services" in the "Mental Health Services" section of non-Medicare *EOCs*, we have made editorial revisions for clarity. There are no changes to coverage of gender-affirming Services.

Glucose monitors

Under "Durable Medical Equipment ('DME') for home use" in the "Cost Share Summary" and "Benefits" sections of the non-Medicare *EOCs*, we have removed the word "blood" from "blood glucose monitors," to ensure that it is clear that we cover both blood glucose monitors that use test strips and continuous glucose monitors. In accord with this change, we have re-alphabetized the bullet points beginning with "Glucose monitors…" in the bulleted lists in which they appear.

Missed Appointment Fee

We have added a new section called "Provider fees" under "Your Copayments and Coinsurance" informing members that some Plan Providers may charge a fee for missed appointments without 24-hour advance notice, except in the case of an emergency. This is not a change in policy, just a clarification in the *EOC*.

Overage Dependent

We are now using the term "overage dependent" rather than "disabled dependent" in the *EOC*, so that the health status of the dependent can be kept confidential.

Pediatric Dental Services Amendment

Under "Payments that count toward the Plan Out-of-Pocket Maximum" in the "Benefits" section of non-Medicare *EOCs*, and "Dental and orthodontic Services" in the "Exclusions" section of non-Medicare *EOCs*, we have removed language explaining to Members that if they have pediatric dental coverage, a Pediatric Dental Services Amendment will be attached to their *EOC*. Pediatric dental coverage is described in a separate *EOC* provided by Delta Dental for plans that include this coverage.

Preventive Services

In the "Definitions" section of non-Medicare *EOCs*, we have clarified that the definition of "Preventive Services" pertains to services that are defined as preventive under the Affordable Care Act ("ACA") and any additional services that we deem to be preventive, as described on our website at **kp.org/prevention**. This is not a change in policy, just a clarification in the *EOC*. The required preventive services are based on recommendations by the U.S. Preventive Services Task Force, Health Resources and Services Administration, and the Centers for Disease Control and Prevention.

Calculating Premiums

To calculate the amount of Full Premiums that apply to a Family (a Subscriber and all of their Dependents):

1. If this *Agreement* includes more than one contract option, determine the coverage (*EOCs* and contract options) that apply to each Member in the Family (for example, Traditional Plan and any Ancillary Coverage).
2. Determine the family role type and Medicare status of each Member (for family role types, please see the "Definitions" section of the *EOC* for the definition of Subscriber, Dependent, and Spouse).
3. Identify the Premiums for each Member for each *EOC* and contract option (including contract options issued through a separate contract) based on the family role type and Medicare status of each Member:
   - Premiums for coverage issued under this *Agreement* appear in the Premium tables below.
   - If this *Agreement* includes a POS Plan contract option (a contract option with one tier underwritten by Health Plan and two tiers underwritten by Kaiser Permanente Insurance Company), the amounts shown below for the POS Plan (for Large Groups) product includes premiums for the Health Plan and Kaiser Permanente Insurance Company portions of Group's POS Plan coverage, and Group submits payment for this coverage as part of Full Premium.
   - If Ancillary Coverage has been issued under a separate contract and Premiums for that coverage are not listed in the Premium tables below, refer to that contract for Premiums. This Ancillary Coverage is part of the contract options selected by Group, and Group submits payment for this Ancillary Coverage as part of Full Premium.
4. Add the amounts of Premiums for each Member together to arrive at the total, Full Premiums required for the Family.

Monthly Premiums for Kaiser Permanente Traditional HMO Plan — *EOC* # 1

TRADITIONAL HMO SCR

Members under age 65 who are not eligible for Medicare

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members under age 65 who are eligible for or have Medicare Part A only

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members under age 65 who are eligible for or have Medicare Part B only

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members under age 65 who are eligible for or have Medicare Parts A&B

Family role type	Premiums
Subscriber	$864.80

Family role type	Premiums
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members under age 65 who are enrolled in another carrier's Medicare Risk product

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members under age 65 when Medicare is secondary

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members age 65 and over whose Medicare eligibility is unknown

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members age 65 and over who are eligible for or have Medicare Part A only

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members age 65 and over who are eligible for or have Medicare Part B only

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members age 65 and over who are eligible for or have Medicare Parts A&B

Family role type	Premiums
Subscriber	$864.80

Family role type	Premiums
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members age 65 and over who are enrolled in another carrier's Medicare Risk product

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members age 65 and over when Medicare is secondary

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Note: Members who are "eligible for" Medicare Part A or B are those who would qualify for Medicare Part A or B coverage if they applied for it. Members who "have" Medicare Part A or B are those who have been granted Medicare Part A or B coverage. Medicare Part A provides inpatient coverage and Part B provides outpatient coverage.

Monthly Premiums for Kaiser Permanente Senior Advantage (HMO) with Part D — *EOC # 2*

SR ADV GRP HMO SCR

Family role type	Medicare Parts A & B	Medicare Part B only
Subscriber	$262.24	$572.90
1st Dependent	$262.24	$572.90
2nd Dependent	$262.24	$572.90
Each additional Dependent	$262.24	$572.90

Monthly Premiums for Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage — *EOC # 3*

SCR WORK AGED ASSIGN

For Members enrolled in Senior Advantage when federal law requires that Group's health care plan be primary and Medicare coverage be secondary, the Premiums are:

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88

Monthly Premiums for American Specialty Health Plans Chiro & Acu Plan — *EOC* # 4

HMO CHIROACU ASH SCR

Family role type	Premiums
Subscriber	$2.19
Spouse	$2.85
1st child without Spouse	$1.53
1st child with Spouse	$1.31

Enrollment Unit Chart

Contract name: AFFIRM INC
Group ID: 235801
Contract: 1

The charts below describe how the coverage your Group has purchased (called *contract options*) are organized into administrative groupings (called *enrollment units*) for the purposes of enrollment and billing. Please keep this document handy for future reference as the information it contains will be helpful when reporting membership changes.

An *Evidence of Coverage* (*EOC*) for each Health Plan coverage that your Group has purchased is incorporated into the enclosed *Group Agreement* (the *EOC* number is the same as the *contract option* number). If your Group has purchased non-Health Plan coverage (such as dental coverage), the carrier(s) for the applicable coverage will send its agreement to your Group under separate cover.

***Contract option*:** A unique *contract option* name and number exists for each coverage option that you offer to your Members. For example, if you offer the same benefits to all of your Members, but have different eligibility rules for different segments of your membership, you will have a separate *contract option* for each coverage option.

Enrollment unit: An *enrollment unit* is a grouping of *contract options* for a specific segment of your Member population for enrollment and billing purposes. If there are *contract options* only available to a specific segment of your Member population, then there will be a distinct *enrollment unit* for that segment. If your Member population is billed separately, there will be a separate *enrollment unit* (or billing unit) for each segment. Note: An enrollment unit may also be referred to as a *subgroup*.

The following are the *enrollment units* associated with this contract:

Enrollment unit number: 0
Enrollment unit name: AFFIRM INC ACTIVES
Billing contact: ATTN: ERC - Affirm

Contract Option	Product name	Contract option name
1	Kaiser Permanente Traditional HMO Plan	TRADITIONAL HMO SCR
2	Kaiser Permanente Senior Advantage (HMO) with Part D	SR ADV GRP HMO SCR
3	Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage	SCR WORK AGED ASSIGN
4	American Specialty Health Plans Chiro & Acu Plan	HMO CHIROACU ASH SCR

Enrollment unit number: 1
Enrollment unit name: AFFIRM INC PART TIME
Billing contact: ATTN: ERC - Affirm

Contract Option	Product name	Contract option name
1	Kaiser Permanente Traditional HMO Plan	TRADITIONAL HMO SCR
2	Kaiser Permanente Senior Advantage (HMO) with Part D	SR ADV GRP HMO SCR
3	Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage	SCR WORK AGED ASSIGN

Contract Option	Product name	Contract option name
4	American Specialty Health Plans Chiro & Acu Plan	HMO CHIROACU ASH SCR

Enrollment unit number: 2
Enrollment unit name: AFFIRM INC INTERNS
Billing contact: ATTN: ERC - Affirm

Contract Option	Product name	Contract option name
1	Kaiser Permanente Traditional HMO Plan	TRADITIONAL HMO SCR
2	Kaiser Permanente Senior Advantage (HMO) with Part D	SR ADV GRP HMO SCR
3	Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage	SCR WORK AGED ASSIGN
4	American Specialty Health Plans Chiro & Acu Plan	HMO CHIROACU ASH SCR

Enrollment unit number: 7000
Enrollment unit name: AFFIRM INC/COBRA
Billing contact: ATTN: ERC - Affirm

Contract Option	Product name	Contract option name
1	Kaiser Permanente Traditional HMO Plan	TRADITIONAL HMO SCR
2	Kaiser Permanente Senior Advantage (HMO) with Part D	SR ADV GRP HMO SCR
3	Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage	SCR WORK AGED ASSIGN
4	American Specialty Health Plans Chiro & Acu Plan	HMO CHIROACU ASH SCR

Enrollment unit number: 7001
Enrollment unit name: AFFIRM INC PART TIME/COBRA
Billing contact: ATTN: ERC - Affirm

Contract Option	Product name	Contract option name
1	Kaiser Permanente Traditional HMO Plan	TRADITIONAL HMO SCR
2	Kaiser Permanente Senior Advantage (HMO) with Part D	SR ADV GRP HMO SCR
3	Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage	SCR WORK AGED ASSIGN
4	American Specialty Health Plans Chiro & Acu Plan	HMO CHIROACU ASH SCR

Enrollment unit number: 7002
Enrollment unit name: AFFIRM INC INTERNS/COBRA
Billing contact: ATTN: ERC - Affirm

Contract Option	Product name	Contract option name
1	Kaiser Permanente Traditional HMO Plan	TRADITIONAL HMO SCR

Contract Option	Product name	Contract option name
2	Kaiser Permanente Senior Advantage (HMO) with Part D	SR ADV GRP HMO SCR
3	Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage	SCR WORK AGED ASSIGN
4	American Specialty Health Plans Chiro & Acu Plan	HMO CHIROACU ASH SCR

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Southern California Region

A nonprofit corporation

Group Agreement for
AFFIRM INC

Group ID: 235801 Contract: 1 Version: 6 Issue Date: October 21, 2025

January 1, 2026, through December 31, 2026

TABLE OF CONTENTS

Introduction 1
Health Plan and Other Ancillary Products 1
Term of *Agreement* and Renewal 1
Term of *Agreement* 1
Renewal 1
Amendment of *Agreement* 2
Amendments Effective on your Group's Anniversary Date 2
Amendments Related to Government Approval 2
Amendment Due to Medicare Changes 2
Amendment Due to Tax or Other Charges 2
Other Amendments 2
Acceptance of Amendments 3
Termination of *Agreement* 3
Termination on Notice 3
Termination Due to Nonacceptance of Amendments 3
Termination for Nonpayment 4
Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information 4
Termination for Violation of Contribution or Participation Requirements 4
Termination for Discontinuance of a Product or all Products within a Market 4
Contribution and Participation Requirements 5
Miscellaneous Provisions 5
Assignment 5
Attorney Fees and Costs 5
Confidential Information about Health Plan or its Affiliates 6
Contract Providers 6
Delegation of Claims Review 7
Electronic Delivery of Written Communications, Contracts, and Other Documents 7
Enrollment Application Requirements 7
Grandfathered Health Plan Coverage 7
Governing Law 7
Member Information 8
No Waiver 8
Nonduplication Agreement 8
Notices 9
Open Enrollment 9
Other Group coverage that covers Essential Health Benefits 10
Reporting Membership Changes and Retroactivity 10
Representation Regarding Waiting Periods 10
Right to Examine Records 11
Social Security and Tax Identification Numbers 11
Premiums 11
Due Date and Payment of Premiums 11
New Members 11
Membership Termination 11
Premium Rebates 12
Medicare 12
Subscriber Contributions for Medicare Part C and Part D Coverage 13
Calculating Premiums 14

Monthly Premiums for Kaiser Permanente Traditional HMO Plan — *EOC* # 1 14
Monthly Premiums for Kaiser Permanente Senior Advantage (HMO) with Part D — *EOC* # 2 16
Monthly Premiums for Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage — *EOC* # 3 17
Monthly Premiums for American Specialty Health Plans Chiro & Acu Plan — *EOC* # 4 17
Agreement Signature Page 18
Acceptance of *Agreement* 18
Binding Arbitration 18
Signatures 18

Introduction

This Group Agreement (*Agreement*), including the *Evidence of Coverage* (*EOC*) and other documents listed below under "Health Plan and Other Ancillary Products," the group application that Group submitted to Health Plan, and any amendments to any of them, all of which are incorporated into this *Agreement* by reference, constitute the contract between Kaiser Foundation Health Plan, Inc., (Health Plan) and AFFIRM INC (Group).

If Group has applied for Ancillary Coverage through Health Plan, provided under a separate contract, it is the intent of Group and Health Plan that coverage under this Agreement and those other contract(s) be treated as one package of benefits for the purposes of term, renewal, termination and payment of Premiums.

In consideration of timely payment of Premium, Health Plan will provide or arrange for covered Services to Members in accord with the documents listed below under "Health Plan and Other Ancillary Products."

Health Plan and Other Ancillary Products

Health Plan products, including Ancillary Coverage offered by Health Plan

Product name	Contract option name for product	*EOC #*
Kaiser Permanente Traditional HMO Plan	TRADITIONAL HMO SCR	1
Kaiser Permanente Senior Advantage (HMO) with Part D	SR ADV GRP HMO SCR	2
Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage	SCR WORK AGED ASSIGN	3
American Specialty Health Plans Chiro & Acu Plan	HMO CHIROACU ASH SCR	4

Pediatric dental coverage

Not applicable

Other Ancillary Coverage

Not applicable

In this *Agreement,* some capitalized terms have special meaning; please see the "Definitions" section in the *EOC* documents for definitions of terms that are used in *EOC* documents and this *Agreement*.

Term of *Agreement* and Renewal

Term of *Agreement*

Unless terminated as set forth in the "Termination of *Agreement*" section, this *Agreement* is effective from January 1, 2026, through December 31, 2026.

Renewal

This *Agreement* does not automatically renew. If Group complies with all of the terms of this *Agreement*, Health Plan will provide prior written notice of any offer to renew the *Agreement*, in a timely manner consistent with applicable state and federal requirements, by doing one of the following:

- Providing Group with a new *Group Agreement* to become effective immediately after termination of this *Agreement*
- Extending the term of this *Agreement* and making other changes pursuant to "Amendments Effective on your Group's Anniversary Date" in the "Amendment of *Agreement*" section

Health Plan will provide Group a renewal notice, which will include a summary of changes to this *Agreement.* The new or extended-term *Group Agreement* will incorporate the changes summarized in the renewal notice. Health Plan will issue to Group the new or extended-term Group Agreement after Group confirms its intent to renew coverage, or 60 days after Group's Anniversary Date if Group does not provide affirmative confirmation of its intent to renew coverage prior to that date.

If Group does not want to renew the *Agreement*, Group must give Health Plan written notice as described under "Termination on Notice" or "Termination due to Nonacceptance of Amendments" in the "Termination of *Agreement*" section.

Note: Your Group's Anniversary Date is January 1.

Amendment of *Agreement*

Amendments Effective on your Group's Anniversary Date

Upon 60 days prior written notice to Group, Health Plan may extend the term of this *Agreement* and make other changes by amending this *Agreement* effective January 1 (the Anniversary Date).

Amendments Related to Government Approval

If Health Plan notified Group that Health Plan had not received all necessary governmental approvals related to this *Agreement*, Health Plan may amend this *Agreement* by giving written notice to Group after receiving all necessary governmental approvals. Any such government-approved provisions go into effect on January 1, 2026 (unless the government requires a later effective date).

Amendment Due to Medicare Changes

Health Plan contracts on a calendar year basis with the Centers for Medicare & Medicaid Services (CMS) to offer Kaiser Permanente Senior Advantage. Health Plan may amend this *Agreement* to change any Kaiser Permanente Senior Advantage *EOCs* and Premiums effective January 1, 2027 (unless the federal government requires or allows a different effective date). The amendment may include an increase or decrease in Premiums and benefits (including Member Cost Sharing and any Medicare Part D coverage level thresholds). Health Plan will give Group written notice of any such amendment.

In addition, Health Plan may amend this *Agreement* at any time by giving written notice to Group, in order to increase any benefits of any Medicare product approved by the Centers for Medicare & Medicaid Services (CMS).

Amendment Due to Tax or Other Charges

If a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Health Plan or Plan Providers (or any of their activities), then upon 60 days prior written notice, Health Plan may increase Group's Premiums to include Group's share of the new or increased tax or charge. Group's share will be determined by dividing the number of Members enrolled through Group by the total number of members enrolled in Health Plan's Southern California Region.

Other Amendments

Health Plan may amend this *Agreement* at any time by giving written notice to Group, in order to address any law or regulatory requirement, which may include an increase in Premiums to reflect an increase in costs to Health Plan or Plan Providers (Health Plan will give Group 60 days prior written notice of any increase in Premiums or reduction in benefits).

Acceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Health Plan written notice of nonacceptance within 15 days after the date of Health Plan's amendment notice, in which case this *Agreement* will terminate pursuant to "Termination due to Nonacceptance of Amendments" in the "Termination of *Agreement*" section.

Termination of *Agreement*

This *Agreement* will terminate under any of the conditions listed below. All rights to benefits under this *Agreement* end on the termination date, except as expressly provided in the "Termination of Membership" or "Continuation of Membership" sections of an *Evidence of Coverage*. The termination date is the first day when this *Agreement* is no longer in effect (for example, if the termination date is January 1, 2027, the last minute this *Agreement* was in effect was at 11:59 p.m. on December 31, 2026).

If Health Plan terminates this *Agreement,* Health Plan will give Group written notice. In the case of "Termination for Nonpayment", "Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information", and "Termination for Discontinuance of a Product or all Products within a Market," Health Plan will provide both advance notice of the termination in addition to a final notice of termination. Within five business days of receipt of an advance or final notice of termination, Group will provide each Subscriber a legible copy of the notice and will give Health Plan proof of that notice was provided including the date thereof.

Termination on Notice

If Group has Kaiser Permanente Senior Advantage Members

If Group has Senior Advantage Members enrolled under this Agreement at the time Health Plan receives written notice from Group that it is terminating this Agreement, Group may terminate this Agreement effective as of the Anniversary Date by giving prior written notice to Health Plan at least 30 days prior to the Anniversary Date, except that the termination will be effective on the first of the month following the Anniversary Date if the Anniversary Date is not the first of the month. Group remains responsible for remitting all amounts payable relating to this Agreement, including Premiums, for the period through the termination date.

If Group does not have Kaiser Permanente Senior Advantage Members

If Group does not have Senior Advantage Members enrolled under this Agreement at the time Health Plan receives written notice from Group that it is terminating this Agreement, Group may terminate this Agreement effective as of the Anniversary Date by giving prior written notice to Health Plan at least 15 days prior to the Anniversary Date, except that termination will be effective on the first of the month following the Anniversary Date if the Anniversary Date is not the first of the month. Group remains responsible for remitting all amounts payable relating to this Agreement, including Premiums, for the period through the termination date.

Termination Due to Nonacceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Health Plan written notice of nonacceptance within 15 days after the date of Health Plan's amendment notice and Group remits all amounts payable related to this *Agreement*, including Premiums, for the period prior to the amendment effective date, in which case this *Agreement* will terminate on the following date, as applicable:

- In the case of amendments described in the "Amendment of *Agreement*" section under "Amendments Related to Government Approval" and "Amendments Due to Medicare Changes," and amendments described under "Other Amendments" that do not require 60 days notice by Health Plan, if Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice of nonacceptance, the termination date will be first of the month following 30 days after Health Plan receives written notice of nonacceptance
- In all other cases, the termination date will be the day before the effective date of the amendment

Termination for Nonpayment

Premiums are due for the Full Premium owed as described in the "Premiums" section. If Health Plan does not receive the required Premium payment for all coverage issued under this *Agreement* on or before the due date, we will provide a notice of start of grace period to Group as described under "Notices" in the "Miscellaneous Provisions" section. This notice will include the following information:

- A statement that we have not received Full Premium payment and that we will terminate this *Agreement* for nonpayment if we do not receive the required Premiums by the specified date
- The amount of Premiums past due

If we do not receive the required Premiums by the date indicated in the notice of start of grace period, the *Agreement* will terminate and all coverage issued under the *Agreement* will end on the date specified in the notice of start of grace period, which will be at least 30 days after the date of the notice. The *Agreement* will remain in effect during this grace period, but upon termination Group will be responsible for paying all past due Premiums, including the Premiums for coverage provided during this grace period.

We will provide notice of termination to Group as described under "Notices" in the "Miscellaneous Provisions" section if we do not receive Full Premium payment within 30 days after the date of the notice of start of grace period.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and effective on a later date with respect to Senior Advantage Members, in order to comply with CMS termination notice requirements.

Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information

If Group commits fraud or intentionally furnishes incorrect or incomplete material information to Health Plan, Health Plan may terminate this *Agreement* by giving advance written notice to Group, and Group is liable for all unpaid Premiums up to the termination date.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and effective on a later date with respect to Senior Advantage Members, in order to comply with CMS termination notice requirements.

Termination for Violation of Contribution or Participation Requirements

If Group fails to comply with Health Plan's participation or contribution requirements (including those discussed in the "Contribution and Participation Requirements" section), Health Plan may terminate this *Agreement* by giving advance written notice to Group, and Group is liable for all unpaid Premiums up to the termination date.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and effective on a later date with respect to Senior Advantage Members, in order to comply with CMS termination notice requirements.

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

Grandfathered products

Health Plan may terminate a particular product or all products offered in a small or large group market as permitted or required by law. If Health Plan discontinues offering a particular grandfathered product in a market, Health Plan may terminate this *Agreement* with respect to that product upon 90 days prior written notice to Group. Health Plan will offer

Group another product that it makes available to groups in the small or large group market, as applicable. If Health Plan discontinues offering all products to groups in a small or large group market, as applicable, Health Plan may terminate this *Agreement* upon 180 days prior written notice to Group and Health Plan will not offer any other product to Group. A "product" is a combination of benefits and services that is defined by a distinct *Evidence of Coverage*.

All other products

Health Plan may terminate a particular product or all products offered in the group market as permitted or required by law. If Health Plan discontinues offering a particular product (other than a grandfathered product) in the group market, Health Plan may terminate this *Agreement* with respect to that product upon 90 days prior written notice to Group. Health Plan will offer Group another product that it makes available in the group market. If Health Plan discontinues offering all products in the group market, Health Plan may terminate this *Agreement* upon 180 days prior written notice to Group and Health Plan will not offer any other product to Group. A "product" is a combination of benefits and services that is defined by a distinct *Evidence of Coverage*.

Contribution and Participation Requirements

No change in Group's contribution or participation requirements listed below is effective for purposes of this *Agreement* unless Health Plan consents in writing. As a condition to consenting to Group's revised contribution and participation requirements, Health Plan may require Group to agree to amend the Premiums, benefits, or other provisions of this *Agreement*.

Group must:

- Ensure that:
  - all Subscribers live or work inside the Service Area applicable to their coverage when they enroll (except that Group must ensure that Subscribers live inside the Service Area applicable to their coverage when they enroll if Group chooses not to have a "live or work" eligibility rule, and that Kaiser Permanente Senior Advantage Members live inside the Service Area applicable to their coverage when they enroll in Senior Advantage and thereafter)
  - at least one employee, proprietor, or partner who lives or works inside the Service Area is eligible to enroll as a Subscriber
- Meet all applicable legal and contractual requirements, such as:
  - meet all Health Plan requirements set forth in the "Rate Assumptions and Requirements" section of the *Rate Proposal* document (Group's Health Plan account manager can provide Group with a copy of the Rate Proposal if Group does not have one)
  - offer enrollment in accord with eligibility requirements in state law (for example, domestic partners must be eligible if married spouses are eligible and disabled dependents must be eligible if dependent children are eligible)

Miscellaneous Provisions

Assignment

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

Attorney Fees and Costs

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

Confidential Information about Health Plan or its Affiliates

For the purposes of this "Confidential Information about Health Plan or its Affiliates" section, "Confidential Information" means any oral, written, or electronic information concerning Health Plan or its affiliates, if the information either is marked "confidential" or is by its nature proprietary or non-public, except that it does not include any of the following:

- Information that is or becomes available to the public other than as a result of disclosure by Group or its employees, advisors, or representatives
- Information that was available to Group or within its knowledge before Health Plan disclosed it to Group
- Information that becomes available to Group from a source other than Health Plan, but only if that source is not bound by a confidentiality agreement with Health Plan

If Group receives any Confidential Information, it will use that information only to evaluate Health Plan and actual or proposed group agreements with Health Plan. Group will ensure that the information is not disclosed to anyone other than a limited number of Group's employees and advisors, and only to the extent necessary in connection with the evaluation of Health Plan and actual or proposed group agreements with Health Plan. Group will inform any such employees and advisors that the information is confidential and that they must treat it confidentially.

Upon Health Plan's request Group will promptly return to Health Plan all Confidential Information, and will destroy any other copies and any notes or other Group documents about the information.

If Group is requested or required (by oral questions, interrogatories, request for information or documents, subpoena, civil investigative demand, or similar process) to disclose any Confidential Information, Group will give Health Plan prompt notice of the request or requirement, and Group will cooperate with Health Plan in seeking to legally avoid the disclosure. If, in the absence of a protective order, Group is legally compelled, in the opinion of its counsel, to disclose any of the information, Health Plan either will seek and obtain appropriate protective orders against the disclosure or will be deemed to waive Group's compliance with the provisions of this "Confidential Information about Health Plan or its Affiliates" section to the extent necessary to satisfy the request or requirement.

Group understands (and will inform any employees and advisors who receive Confidential Information) that United States securities laws prohibit anyone who has material non-public information about a company from buying or selling that company's securities in reliance upon that information or from communicating the information to any other person or entity under circumstances in which it is reasonably foreseeable that the person or entity is likely to buy or sell that company's securities in reliance upon the information. Group agrees that it and its affiliates, associates, employees, agents, and advisors will not rely on any Confidential Information in directly or indirectly buying or selling any Health Plan securities.

Monetary damages would not be a sufficient remedy for any breach or threatened breach of this "Confidential Information about Health Plan or its Affiliates" section. Health Plan will be entitled to equitable relief by way of injunction or specific performance if Group or any of its officers, directors, employees, attorneys, accountants, agents, advisors, or representatives breach, or threaten to breach, any of the provisions of this "Confidential Information about Health Plan or its Affiliates" section.

Group's obligations under this "Confidential Information about Health Plan or its Affiliates" section will continue indefinitely and will survive the termination or expiration of this *Agreement.*

Contract Providers

Health Plan will give Group written notice within a reasonable time of any termination or breach of contract by, or inability to perform of, any health care provider that contracts with Health Plan if Group may be materially and adversely affected thereby.

Delegation of Claims Review

Group delegates to Health Plan the discretion to determine whether a Member is entitled to benefits under this *Agreement*. In making these determinations, Health Plan has discretionary authority to review claims in accord with the procedures contained in this *Agreement* and to construe this *Agreement* to determine whether the Member is entitled to benefits. If coverage under an *EOC* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), Health Plan is a "named claims fiduciary" to review claims under that *EOC*.

Electronic Delivery of Written Communications, Contracts, and Other Documents

Written communications, contracts, and other documents may be provided electronically to Group, as allowed by law. If provided by posting to an electronic system, Health Plan will inform Group when a document is available for retrieval. A communication or document that is sent electronically shall be deemed received when the Group is able to retrieve the electronic communication or document from the electronic or information processing system designated for the purpose of receiving electronic records or information of the type sent. Communications and documents that may be delivered electronically include this *Agreement*, the annual renewal notice, and other communications between Group and Health Plan as allowed by law to be delivered electronically. A notice of termination will not be delivered electronically.

Group may opt-out of electronic delivery of communications and documents at any time by providing notice to Health Plan.

Enrollment Application Requirements

Group must use enrollment application forms that are provided by Health Plan. If Group wants to use a different form or system for enrolling Members, Group must obtain Health Plan's prior approval of the form or system. Other forms and systems include a "universal" enrollment application form, interactive voice recording (IVR) enrollment system, or intranet online enrollment system. All forms and systems must meet Health Plan requirements for enrolling Members, including disclosure of binding arbitration in accord with Section 1363.1 of the California Health and Safety Code and other applicable law. Group must retain documentation of each Member's acceptance of the use of binding arbitration indefinitely, and upon request, must be able to produce documentation relating to a specific Member to Health Plan at any time. In the event that the contract between Health Plan and Group terminates or Group is unable to comply with this document retention requirement, Group must transfer possession of all such documentation to Health Plan in a mutually agreeable manner. Group's Health Plan account manager can provide Group with Health Plan's current requirements for enrollment application forms and systems.

Grandfathered Health Plan Coverage

For any coverage identified in an EOC as a "grandfathered health plan" under the Patient Protection and Affordable Care Act and regulations, Group must immediately inform Health Plan if this coverage does not meet (or no longer meets) the requirements for grandfathered status including but not limited to any change in its contribution rate to the cost of any grandfathered health plans during the plan year. Group represents that, for any coverage identified as a "grandfathered health plan" in the applicable *EOC*, Group has not decreased its contribution rate more than five percent (5%) for any rate tier for such grandfathered health plan when compared to the contribution rate in effect on March 23, 2010 for the same plan. Health Plan will rely on Group's representation in issuing and continuing any and all grandfathered health plan coverage.

Governing Law

Except as preempted by federal law, this *Agreement* will be governed in accord with California law and any provision that is required to be in this *Agreement* by state or federal law, shall bind Group and Health Plan whether or not set forth in this *Agreement*.

Member Information

Group will inform Members and prospective Members of eligibility requirements for Subscribers and Dependents and when coverage becomes effective and terminates.

When Health Plan notifies Group about changes to this *Agreement* or provides Group other information that affects Members, Group will disseminate the information to Members by the next regular communication to them, but in no event later than 30 days after Group receives the information.

For each Health Plan coverage included in this *Agreement*, Health Plan will provide Group with the following disclosures for Group to distribute in accord with applicable laws, including the Medicare-as-Secondary-Payer laws ("Member Materials"):

- A *Disclosure Form* (*DF*) for each non-Medicare coverage. Group will provide *DFs* (or combined *EOC/DFs*) to Subscribers and potential Subscribers when the coverage is offered
- A *Summary of Benefits and Coverage* (*SBC*) for each non-Medicare coverage other than retiree plans with fewer than two current employees. Group will provide electronic or paper *SBCs* to Members and potential Members to the extent required by law, except that Health Plan will provide *SBCs* to Members who make a request to Health Plan
- Pre-enrollment materials that CMS requires for Kaiser Permanente Senior Advantage coverage, which are available upon request from Health Plan. Group will provide these materials to potential Members before they enroll in Senior Advantage coverage
- An *EOC* for each non-Medicare coverage. Group will provide *EOCs* (or combined *EOC/DFs*) to Subscribers, except that Health Plan will provide *EOCs* (or combined *EOC/DFs*) to Members and potential Members who make a request to Health Plan

If Group receives the *Agreement* or Member Materials in electronic form, Group is not authorized to modify or alter in any way the text or the formatting of the electronic *Agreement* or Member Materials.

Health Plan assumes no responsibility for any changes in text or formatting that may occur in the *Agreement* or Member Materials after they are provided to Group. If Group posts the electronic *Agreement* or Member Materials on its intranet site, it shall do so in such a way so as to permit employees of Group to download and print a complete and accurate copy of the *Agreement* or Member Materials.

In the event Health Plan reasonably concludes that Group is either using the electronic *Agreement* or Member Materials in a manner not permitted by this *Agreement* or is not providing Subscribers with access to the Member Materials in accord with applicable laws, then Health Plan will print copies of the *Agreement* or Member Materials and Group will cooperate with Health Plan to ensure that printed copies of the *Agreement* or Member Materials are provided in a timely manner to all employees of Group enrolled with Health Plan. Group agrees to reimburse Health Plan for the reasonable cost of printing and delivering the *Agreement* or Member Materials.

No Waiver

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

Nonduplication Agreement

Health Plan agrees to undertake performance of the following regulatory requirements, and Group may rely on Health Plan's performance in order to satisfy its obligation to perform the same activities with respect to the health plan coverages issued to Group by Health Plan:

- Preparation and publication of machine-readable files on a public website for in-network rates and billed charges and allowed amounts for out-of-network providers in the required form and manner as set forth in applicable regulations and any sub-regulatory guidance
- Provision of an internet, self-service tool as well as paper reports and telephone assistance to provide personalized estimates of cost sharing for 500 shoppable services beginning on January 1, 2023, and for all covered services as of January 1, 2024 as set forth in applicable regulations and any sub-regulatory guidance
- Annual reporting of prescription drug and health care costs reporting required to be furnished in accordance with applicable regulations and any sub-regulatory guidance
- Publication of a consumer notice regarding federal and, when applicable, any state legal requirements related to balance billing by non-participating providers in accordance with applicable regulations and any sub-regulatory guidance
- Annual reporting of data related to the provision and cost of air ambulance services for 2022 and 2023 in the required form and manner as set forth in applicable regulations and any sub-regulatory guidance
- Annual submission of a Gag Clause Prohibition Compliance Attestation in the required form and manner as set forth in applicable regulations, if any, and sub-regulatory guidance

Notices

Notice under this Agreement shall be in writing and is deemed given when delivered in person or deposited in the U.S. mail. Notice may also be provided by email if Group has furnished its email address as part of its address of record, and as allowed by law. Health Plan or Group may change its addresses, or email address, for notices by giving written notice to the other.

Notices from Health Plan to Group must be sent to:

COURTNEY WAITE, VICE PRESIDENT, TOTAL REWARDS
AFFIRM INC
650 CALIFORNIA ST FL 12
SAN FRANCISCO, CA 94108-2716

If Group has chosen to receive group agreements electronically through Health Plan's website at **kp.org/yourcontract**, Health Plan will send a notice to Group when a group agreement has been posted to that website.

Note: When Health Plan sends Group a new (renewed) *Agreement*, Health Plan will enclose a summary of changes that discusses the changes Health Plan has made to the *Group Agreement*. If Group wants information about changes before receiving the *Agreement*, Group may request advance information from their Health Plan account manager. Also, if Group designates a third party in writing (for example, "Broker of Record" statements), Health Plan may send the advance information to the third party rather than to Group (unless Group requests a copy too).

Notices from Group to Health Plan must be sent to:

Kaiser Permanente
1 Kaiser Plaza
Oakland, CA 94612
Attn: Thomas A. Curtin Jr., Senior Vice President, Commercial Group Business

Open Enrollment

Group must hold an annual open enrollment period during which all eligible people, in accord with state law, may enroll in Health Plan or in any other health care plan available through Group. Also, Group must not hold open enrollment for 2027 until Group receives its 2027 group agreement Premium and coverage information from Health Plan. If Group holds the open enrollment without receiving 2027 group agreement Premium and coverage information, Health Plan may change Premiums and coverage (including benefits and Cost Sharing) when it offers to renew Group's Agreement as described under "Renewal" in the "Term of Agreement and Renewal" section.

Other Group coverage that covers Essential Health Benefits

For each non-grandfathered non-Medicare Health Plan coverage, except for any retiree-only coverage, Group must do all of the following if Group provides Health Plan Members with other medical or dental coverage (for example, separate pharmacy coverage) that covers any Essential Health Benefits:

- Notify Health Plan of the out-of-pocket maximum (OOPM) that applies to the Essential Health Benefits in each of the other medical or dental coverage.
- Ensure that the sum of the OOPM in Health Plan's coverage plus the OOPMs that apply to Essential Health Benefits in all of the other medical and dental coverage does not exceed the annual limitation on cost sharing described in 45 CFR 156.130.

Reporting Membership Changes and Retroactivity

Group must report membership changes (including sending appropriate membership forms) within the time limit for retroactive changes and in accord with any applicable "rescission" provisions of the Patient Protection and Affordable Care Act and regulations. Except for Senior Advantage membership terminations discussed below, the time limit for retroactive membership changes is the calendar month when Health Plan's California Service Center receives Group's notification of the change plus the previous 2 months.

Representation regarding communication of membership changes

Group represents that its communication regarding membership changes to Health Plan is accurate. Group and its representative are bound by all membership data, including any changes or updates that it, or its representative, submits to Health Plan via any medium, electronic or otherwise, including but not limited to the following:

- Electronic data submissions regarding enrollment and eligibility
- Health Plan approved online tool for submission of data
- Paper enrollments submitted through postal mail or fax

Health Plan's Administrative Handbook includes the details about how to report membership changes. Group's Health Plan account manager can provide Group with an Administrative Handbook if Group does not have one.

Involuntary Kaiser Permanente Senior Advantage Membership Terminations

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

Voluntary Kaiser Permanente Senior Advantage Membership Terminations

If Health Plan's California Service Center receives a disenrollment notice from CMS or a membership termination request from the Member, the membership termination date will be in accord with CMS requirements.

Representation Regarding Waiting Periods

By entering into this Agreement, Group hereby represents that Group does not impose a waiting period exceeding 90 days on employees who meet Group's eligibility requirements. For purposes of this requirement, a "waiting period" is the period that must pass before coverage for an individual who is otherwise eligible to enroll in non-Medicare coverage under the

terms of a group health plan can become effective in accord with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

In addition, Group represents that eligibility data provided by the Group to Health Plan will include coverage effective dates for Group's employees that correctly account for eligibility in compliance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations and will not exceed the waiting period established by Group. For example, if the hire date of an otherwise-eligible employee is January 19, the waiting period begins on January 19 and the effective date of coverage cannot be any later than April 19. Note: If the effective date of your Group's coverage is always on the first day of the month, in this example the effective date cannot be any later than April 1.

Right to Examine Records

Upon reasonable notice, Health Plan may examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement***.**

Social Security and Tax Identification Numbers

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

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

Premiums

Only Members for whom Health Plan (or its designee) has received the Full Premium payment as described below are entitled to coverage under this *Agreement*, and then only for the period for which Health Plan (or its designee) has received required Premium payment. Group is responsible for paying Premiums, except that Members who have Cal-COBRA coverage under an *EOC* that is included in this *Agreement* are responsible for paying Premiums for Cal-COBRA coverage.

Due Date and Payment of Premiums

The payment due date for each enrollment unit (or subgroup) associated with Group will be reflected on the monthly membership invoice if applicable to Group (if not applicable, then as specified in writing by Health Plan). If Group does not pay Full Premiums by the first of the coverage month, the Premiums may include an additional administrative charge upon renewal. "Full Premiums" means 100 percent of monthly Premiums for all of the coverage issued to each enrolled Member, as set forth under "Calculating Premiums" in this "Premiums" section.

New Members

Premiums are payable for the entire month for a new Member whose coverage effective date falls between the first day of the month and the fifteenth day of the month. No Premiums are due for the month for a new Member whose coverage becomes effective after the fifteenth day of that month.

Note: Membership begins at the beginning (12:00 a.m.) of the effective date of coverage.

Membership Termination

Premiums are payable for the entire month for a Member whose last day of coverage is any day during that month.

Note: The membership termination date is the first day a Member is not covered (for example, if the termination date is January 1, 2027, the last minute of coverage was at 11:59 p.m. on December 31, 2026).

Involuntary Kaiser Permanente Senior Advantage Membership Terminations

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

Voluntary Kaiser Permanente Senior Advantage Membership Terminations

If Health Plan's California Service Center receives a disenrollment notice from CMS or a membership termination request from the Member, the membership termination date will be in accord with CMS requirements.

Premium Rebates

If state or federal law requires Health Plan to rebate premiums from this or any earlier contract year and Health Plan rebates premiums to Group, Group represents that Group will use that rebate for the benefit of Members, in a manner consistent with the requirements of the Public Health Service Act and the Affordable Care Act and if applicable with the obligations of a fiduciary under the Employee Retirement Income Security Act (ERISA).

Medicare

Medicare as primary coverage

For Members who are (or the subscriber in the family is) retired, age 65 or over, and eligible for Medicare as primary coverage, Premiums are based on the assumption that Health Plan or its designee will receive Medicare payments for Medicare-covered services provided to Members whose Medicare coverage is primary. If a Member age 65 or over is (or becomes) eligible for Medicare as primary coverage and is not for any reason enrolled through Group under a Kaiser Permanente Senior Advantage *EOC* (including inability to enroll under that *EOC* because they do not meet the plan's eligibility requirements, the plan is not available through Group, or the plan is closed to enrollment), Group must pay the Premiums listed below for the *EOC* under which the Member is enrolled that apply to Members age 65 or over who are not enrolled through Group under one of Health Plan's Medicare plans.

If a Member age 65 or over who is eligible for Medicare as primary coverage and enrolled under a Kaiser Permanente Senior Advantage *EOC* is no longer eligible for that plan, Health Plan may transfer the Member's membership to one of Group's plans that does not require Members to have Medicare, and Group must pay the Premiums listed below for the *EOC* under which the Member is enrolled that apply to Members age 65 or over who are not enrolled through Group under one of Health Plan's Medicare plans.

Medicare as secondary coverage

Medicare is the primary coverage except when federal law requires that Group's health care coverage be primary and Medicare coverage be secondary. Members entitled to Medicare when Medicare is secondary by law are subject to the same Premiums and receive the same benefits as Members who are under age 65 and not eligible for Medicare. In addition, Members for whom Medicare is secondary who meet the Kaiser Permanente Senior Advantage eligibility requirements may also enroll in the Senior Advantage plan under this *Agreement* that is applicable when Medicare is secondary. These Members receive the benefits and coverage described in both the *EOC* for the non-Medicare plan (the plan that does not require Members to have Medicare) and the Senior Advantage *EOC* that is applicable when Medicare is secondary.

Subscriber Contributions for Medicare Part C and Part D Coverage

Medicare Part C coverage

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

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

Medicare Part D coverage

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

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

consequences of the Member's enrolling in the Member's current coverage, as compared to enrolling in another Medicare Part D plan with a monthly premium equal to or less than the Low Income Subsidy amount

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

Calculating Premiums

To calculate the amount of Full Premiums that apply to a Family (a Subscriber and all of their Dependents):

1. If this *Agreement* includes more than one contract option, determine the coverage (*EOCs* and contract options) that apply to each Member in the Family (for example, Traditional Plan and any Ancillary Coverage).
2. Determine the family role type and Medicare status of each Member (for family role types, please see the "Definitions" section of the *EOC* for the definition of Subscriber, Dependent, and Spouse).
3. Identify the Premiums for each Member for each *EOC* and contract option (including contract options issued through a separate contract) based on the family role type and Medicare status of each Member:
   - Premiums for coverage issued under this *Agreement* appear in the Premium tables below.
   - If this *Agreement* includes a POS Plan contract option (a contract option with one tier underwritten by Health Plan and two tiers underwritten by Kaiser Permanente Insurance Company), the amounts shown below for the POS Plan (for Large Groups) product includes premiums for the Health Plan and Kaiser Permanente Insurance Company portions of Group's POS Plan coverage, and Group submits payment for this coverage as part of Full Premium.
   - If Ancillary Coverage has been issued under a separate contract and Premiums for that coverage are not listed in the Premium tables below, refer to that contract for Premiums. This Ancillary Coverage is part of the contract options selected by Group, and Group submits payment for this Ancillary Coverage as part of Full Premium.
4. Add the amounts of Premiums for each Member together to arrive at the total, Full Premiums required for the Family.

Monthly Premiums for Kaiser Permanente Traditional HMO Plan — *EOC* # 1

TRADITIONAL HMO SCR

Members under age 65 who are not eligible for Medicare

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members under age 65 who are eligible for or have Medicare Part A only

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members under age 65 who are eligible for or have Medicare Part B only

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24

Family role type	Premiums
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members under age 65 who are eligible for or have Medicare Parts A&B

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members under age 65 who are enrolled in another carrier's Medicare Risk product

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members under age 65 when Medicare is secondary

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members age 65 and over whose Medicare eligibility is unknown

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members age 65 and over who are eligible for or have Medicare Part A only

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members age 65 and over who are eligible for or have Medicare Part B only

Family role type	Premiums
Subscriber	$864.80

Family role type	Premiums
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members age 65 and over who are eligible for or have Medicare Parts A&B

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members age 65 and over who are enrolled in another carrier's Medicare Risk product

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Members age 65 and over when Medicare is secondary

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88
Each additional Dependent	$0.00

Note: Members who are "eligible for" Medicare Part A or B are those who would qualify for Medicare Part A or B coverage if they applied for it. Members who "have" Medicare Part A or B are those who have been granted Medicare Part A or B coverage. Medicare Part A provides inpatient coverage and Part B provides outpatient coverage.

Monthly Premiums for Kaiser Permanente Senior Advantage (HMO) with Part D — *EOC # 2*

SR ADV GRP HMO SCR

Family role type	Medicare Parts A & B	Medicare Part B only
Subscriber	$262.24	$572.90
1st Dependent	$262.24	$572.90
2nd Dependent	$262.24	$572.90
Each additional Dependent	$262.24	$572.90

Monthly Premiums for Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage — *EOC* # 3

SCR WORK AGED ASSIGN

For Members enrolled in Senior Advantage when federal law requires that Group's health care plan be primary and Medicare coverage be secondary, the Premiums are:

Family role type	Premiums
Subscriber	$864.80
Spouse	$1,124.24
1st child without Spouse	$605.36
1st child with Spouse	$518.88

Monthly Premiums for American Specialty Health Plans Chiro & Acu Plan — *EOC* # 4

HMO CHIROACU ASH SCR

Family role type	Premiums
Subscriber	$2.19
Spouse	$2.85
1st child without Spouse	$1.53
1st child with Spouse	$1.31

Agreement Signature Page

Acceptance of *Agreement*

Group acknowledges acceptance of this *Agreement* by signing the Signature Page and returning it to Health Plan. If Group does not return it to Health Plan, Group will be deemed as having accepted this *Agreement* if Group pays Health Plan any amount toward Premiums.

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

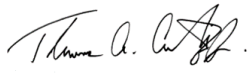
Binding Arbitration

As more fully set forth in the arbitration provision in the applicable *Evidence of Coverage*, disputes between Members, their heirs, relatives, or associated parties (on the one hand) and Health Plan, Kaiser Permanente health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising out of or related to this *Agreement*, including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this *Agreement*, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. Members enrolled under this *Agreement* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the applicable *Evidence of Coverage* except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

Signatures

Kaiser Foundation Health Plan, Inc., Southern California Region



Thomas A. Curtin Jr.
Authorized officer
Senior Vice President, Commercial Group Business
October 21, 2025

AFFIRM INC

Authorized Group officer signature

Print name and title Date

Please keep this copy of the signature page with your *Agreement*. An extra copy is included in your contract package to sign and return:

- **By mail:** Kaiser Permanente, California Service Center, P.O. Box 23448, San Diego, CA 92193-3448.
- **By fax:** 1-855-355-5334

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Southern California Region

A nonprofit corporation

EOC #1 - Kaiser Permanente Traditional HMO Plan Evidence of Coverage for
AFFIRM INC

Group ID: 235801 Contract: 1 Version: 6 *EOC* Number: 1 Issue Date: October 21, 2025

January 1, 2026, through December 31, 2026

Member Services
24 hours a day, seven days a week (closed holidays)
1-800-464-4000 (TTY users call **711**)
kp.org

TABLE OF CONTENTS FOR EOC #1

Cost Share Summary 1
- Accumulation Period 1
- Deductibles and Out-of-Pocket Maximums 1
- Cost Share Summary Tables by Benefit 1
- CARE Plan 18
- Health Care Treatment Following Rape or Sexual Assault 18

Introduction 19
- About Kaiser Permanente 19
- Term of this *EOC* 19

Definitions 20

Premiums, Eligibility, and Enrollment 26
- Premiums 26
- Who Is Eligible 27
- How to Enroll and When Coverage Begins 29

How to Obtain Services 31
- Routine Care 32
- Urgent Care 32
- Emergency Services 32
- Not Sure What Kind of Care You Need? 33
- Your Personal Plan Physician 34
- Getting a Referral 34
- Travel and Lodging for Certain Services 36
- Second Opinions 37
- Contracts with Plan Providers 37
- Receiving Care Outside of Your Home Region 37
- Your ID Card 38
- Timely Access to Care 38
- Getting Assistance 39

Plan Facilities 40

Benefits 40
- Your Cost Share 41
- Administered Drugs and Products 44
- Ambulance Services 44
- Bariatric Surgery 45
- Dental and Orthodontic Services 45
- Dialysis Care 46
- Durable Medical Equipment (“DME”) for Home Use 46
- Emergency Services and Urgent Care 48
- Fertility Services 49
- Fertility Preservation Services for Iatrogenic Infertility 49
- Health Education 51
- Hearing Services 51
- Home Health Care 52
- Hospice Care 52
- Hospital Inpatient Services 53
- Injury to Teeth 54
- Mental Health Services 54

Office Visits 55
Ostomy and Urological Supplies 55
Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services 56
Outpatient Pharmacy Services 56
Outpatient Surgery and Outpatient Procedures 59
Preventive Services 60
Prosthetic and Orthotic Devices 60
Reconstructive Surgery 62
Rehabilitative and Habilitative Services 62
Reproductive Health Services 63
Services in Connection with a Clinical Trial 63
Skilled Nursing Facility Care 64
Substance Use Disorder Treatment 64
Telehealth Visits 65
Transplant Services 65
Vision Services for Adult Members 66
Vision Services for Pediatric Members 67
Exclusions, Limitations, Coordination of Benefits, and Reductions 68
Exclusions 68
Limitations 72
Coordination of Benefits 72
Reductions 72
Post-Service Claims and Appeals 74
Who May File 75
Supporting Documents 75
Initial Claims 76
Appeals 77
External Review 77
Additional Review 77
Dispute Resolution 78
Grievances 78
Independent Review Organization for Non-Formulary Outpatient Prescription Drug Requests 81
Department of Managed Health Care Complaints 81
Independent Medical Review ("IMR") 81
Office of Civil Rights Complaints 82
Additional Review 82
Binding Arbitration 82
Termination of Membership 85
Termination Due to Loss of Eligibility 85
Termination of *Agreement* 85
Termination for Cause 85
Termination of a Product or all Products 85
Payments after Termination 85
State Review of Membership Termination 85
Continuation of Membership 86
Continuation of Group Coverage 86
Continuation of Coverage under an Individual Plan 88
Miscellaneous Provisions 89
Administration of *Agreement* 89
Advance Health Care Directives 89
Amendment of *Agreement* 89

Applications and Statements 89
Assignment 89
Attorney and Advocate Fees and Expenses 89
Claims Review Authority 89
EOC Binding on Members 90
ERISA Notices 90
Governing Law 90
Group and Members Not Our Agents 90
Member Rights and Responsibilities 90
No Waiver 92
Notices Regarding Your Coverage 92
Overpayment Recovery 92
Privacy Practices 92
Public Policy Participation 93
Helpful Information 93
How to Obtain this *EOC* in Other Formats 93
Provider Directory 93
Online Tools and Resources 93
Document Delivery Preferences 93
How to Reach Us 93
Payment Responsibility 95

Cost Share Summary

This "Cost Share Summary" is part of your Evidence of Coverage ("*EOC"*) and is meant to explain the amount you will pay for covered Services under this plan. It does not provide a full description of your benefits. For a full description of your benefits, including any limitations and exclusions, please read this entire *EOC*, including any amendments, carefully.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Deductibles and Out-of-Pocket Maximums

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

If your Group's plan changes during an Accumulation Period, your deductibles and out-of-pocket maximums may increase or decrease, which may change the total amount you must accumulate to reach the deductibles or out-of-pocket maximums during that Accumulation Period.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Deductible	None	None	None
Drug Deductible	None	None	None
Plan Out-of-Pocket Maximum ("OOPM")	$1,500	$1,500	$3,000

Cost Share Summary Tables by Benefit

How to read the Cost Share summary tables

Each table below explains the Cost Share for a category of benefits. Specific Services related to the benefit are described in the first column of each table. For a detailed description of coverage for a particular benefit, refer to the same benefit heading in the "Benefits" section of this *EOC*.

- **Copayment / Coinsurance**. This column describes the Cost Share you will pay for Services after you have met your Plan Deductible or Drug Deductible, if applicable. (Please see the "Deductibles and Out-of-Pocket Maximums" section above to determine if your plan includes deductibles.) If the Services are not covered in your plan, this column will read "Not covered." If we provide an Allowance that you can use toward the cost of the Services, this column will include the Allowance.
- **Subject to Deductible**. This column explains whether the Cost Share you pay for Services is subject to a Plan Deductible or Drug Deductible. If the Services are subject to a deductible, you will pay Charges for those Services until you have met your deductible. If the Services are subject to a deductible, there will be a "✓" or "D" in this column, depending on which deductible applies ("✓" for Plan Deductible, "D" for Drug Deductible). If the Services do not apply to a deductible, or if your plan does not include a deductible, this column will be blank. For a more detailed explanation of deductibles, refer to "Plan Deductible" and "Drug Deductible" in the "Benefits" section of this *EOC*.
- **Applies to OOPM**. This column explains whether the Cost Share you pay for Services counts toward the Plan Out-of-Pocket Maximum ("OOPM") after you have met any applicable deductible. If the Services count toward the Plan OOPM, there will be a "✓" in this column. If the Services do not count toward the Plan OOPM, this column will be blank. For a more detailed explanation of the Plan OOPM, refer to "Plan Out-of-Pocket Maximum" in the "Benefits" section of this *EOC*.

Administered drugs and products

Description of Administered Drugs and Products Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Whole blood, red blood cells, plasma, and platelets	No charge		✓
Allergy antigens (including administration)	$5 per visit		✓
Cancer chemotherapy drugs and adjuncts	No charge		✓
Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products (“biologics”) derived from tissue, cells, or blood	No charge		✓
Administered COVID-19 therapeutics from Plan Providers	No charge		✓
Administered COVID-19 therapeutics from Non-Plan Providers	50% Coinsurance		
All other administered drugs and products	No charge		✓
Drugs and products administered to you during a home visit	No charge		✓

Ambulance Services

Description of Ambulance Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Emergency ambulance Services	$75 per trip		✓
Nonemergency ambulance and psychiatric transport van Services	$75 per trip		✓

Dialysis care

Description of Dialysis Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Equipment and supplies for home hemodialysis and home peritoneal dialysis	No charge		✓
One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment	No charge		✓
Hemodialysis and peritoneal dialysis treatment at a Plan Facility	$15 per visit		✓

Durable Medical Equipment ("DME") for home use

Description of DME Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Glucose monitors for diabetes blood testing and their supplies	20% Coinsurance		✓
Peak flow meters	20% Coinsurance		✓
Insulin pumps and supplies to operate the pump	20% Coinsurance		✓
Other Base DME Items as described in this *EOC*	20% Coinsurance		✓
Supplemental DME items as described in this *EOC*	20% Coinsurance up to a $2,000 benefit limit per Accumulation Period		
Retail-grade milk pumps	No charge		✓
Hospital-grade milk pumps	No charge		✓

Emergency Services and Urgent Care

Description of Emergency Services and Urgent Care	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Emergency department visits	$100 per visit		✓
Urgent Care visits	$15 per visit		✓

Note: If you are admitted to the hospital as an inpatient from the emergency department, the emergency department visits Cost Share above does not apply. Instead, the Services you received in the emergency department, including any observation stay, if applicable, will be considered part of your hospital inpatient stay. For the Cost Share for inpatient Services, refer to "Hospital inpatient Services" in this "Cost Share Summary." The emergency department Cost Share does apply if you are admitted for observation but are not admitted as an inpatient.

Fertility Services

Description of Fertility Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Office visits	$15 per visit		✓

Description of Fertility Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort (oocyte retrievals limited to three per lifetime)	$100 per procedure		✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	$15 per procedure		✓
Outpatient imaging	No charge		✓
Outpatient laboratory	No charge		✓
Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	$250 per admission		✓

Health education

Description of Health Education Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Covered health education programs, which may include programs provided online and counseling over the phone	No charge		✓
Individual counseling during an office visit related to tobacco cessation	No charge		✓
Individual counseling during an office visit related to diabetes management	No charge		✓
Other covered individual counseling when the office visit is solely for health education	No charge		✓
Covered health education materials	No charge		✓

Hearing Services

Description of Hearing Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hearing exams with an audiologist to determine the need for hearing correction	$15 per visit		✓

Description of Hearing Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Physician Specialist Visits to diagnose and treat hearing problems	$15 per visit		✓
Hearing aids, including, fitting, counseling, adjustment, cleaning, and inspection	We provide a $3,500 Allowance for each ear every 36 months		

Home health care

Description of Home Health Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Home health care Services (100 visits per Accumulation Period)	No charge		✓

Hospice care

Description of Hospice Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospice Services	No charge		✓

Hospital inpatient Services

Description of Hospital Inpatient Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospital inpatient stays	$250 per admission		✓

Injury to teeth

Description of Injury to Teeth Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Accidental injury to teeth	Not covered		

Mental health Services

Description of Mental Health Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient mental health hospital stays	$250 per admission		✓
Individual mental health evaluation and treatment	$15 per visit		✓

Description of Mental Health Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Group mental health treatment	$7 per visit		✓
Partial hospitalization	No charge		✓
Other intensive psychiatric treatment programs	No charge		✓
Residential mental health treatment Services	No charge		✓
Behavioral Health Treatment for Autism Spectrum Disorder	No charge		✓
Electroconvulsive therapy	$15 per visit		✓
Transcranial magnetic stimulation	$15 per visit		✓

Office visits

Description of Office Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits that are not described elsewhere in this "Cost Share Summary"	$15 per visit		✓
Physician Specialist Visits that are not described elsewhere in this "Cost Share Summary"	$15 per visit		✓
Group appointments that are not described elsewhere in this "Cost Share Summary"	$7 per visit		✓
Acupuncture Services	$15 per visit		✓

Ostomy and urological supplies

Description of Ostomy and Urological Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Ostomy and urological supplies as described in this *EOC*	No charge		✓

Outpatient imaging, laboratory, and other diagnostic and treatment Services

Description of Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans	No charge		✓
Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds	No charge		✓
Nuclear medicine	No charge		✓
Routine retinal photography screenings	No charge		✓
Routine laboratory tests to monitor the effectiveness of dialysis	No charge		✓
Over-the-counter COVID-19 tests obtained from Plan Providers as described in this EOC (up to a total of 8 tests from Plan Providers and Non-Plan Providers per calendar month)	No charge		✓
Over-the-counter COVID-19 tests obtained from Non-Plan Providers as described in this EOC (up to a total of 8 tests from Plan Providers and Non-Plan Providers per calendar month, not to exceed $12 per test, including all fees and taxes, if you obtain the test from a Non-Plan Provider)	50% Coinsurance		
Laboratory tests to diagnose or screen for COVID-19 obtained from Plan Providers	No charge		✓
Laboratory tests to diagnose or screen for COVID-19 obtained from Non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care)	50% Coinsurance		
All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available)	No charge		✓
Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs and EEGs)	No charge		✓
Radiation therapy	No charge		✓
Ultraviolet light treatments (including ultraviolet light therapy equipment as described in this *EOC*)	No charge		✓

Outpatient pharmacy Services

If the "Cost Share at a Plan Pharmacy" column in this section provides Cost Share for a 30-day supply and your Plan Physician prescribes more than this, you may be able to obtain more than a 30-day supply at one time up to the day supply

limit for that drug. Applicable Cost Share will apply. For example, two 30-day copayments may be due when picking up a 60-day prescription, three copayments may be due when picking up a 100-day prescription at the pharmacy.

Most items

Description of Most Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on Tier 1 not described elsewhere in this "Cost Share Summary"	$10 for up to a 30-day supply	$20 for up to a 100-day supply		✓
Items on Tier 2 not described elsewhere in this "Cost Share Summary"	$20 for up to a 30-day supply	$40 for up to a 100-day supply		✓
Items on Tier 4 not described elsewhere in this "Cost Share Summary"	20% Coinsurance (not to exceed $150) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Base drugs, supplies, and supplements

Description of Base Drugs, Supplies and Supplements	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Hematopoietic agents for dialysis	No charge for up to a 30-day supply	Not available		✓
Elemental dietary enteral formula when used as a primary therapy for regional enteritis	No charge for up to a 30-day supply	Not available		✓
All other items on Tier 1 as described in this *EOC*	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
All other items on Tier 2 as described in this *EOC*	$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
All other items on Tier 4 as described in this *EOC*	20% Coinsurance (not to exceed $150) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Anticancer drugs and certain critical adjuncts following a diagnosis of cancer

Description of Anticancer Drugs and Certain Critical Adjuncts	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Oral anticancer drugs on Tier 1	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Oral anticancer drugs on Tier 2	$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Oral anticancer drugs on Tier 4	20% Coinsurance (not to exceed $150) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on Tier 1	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on Tier 2	$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on Tier 4	20% Coinsurance (not to exceed $150) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Home infusion drugs

Description of Home Infusion Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Home infusion drugs	No charge for up to a 30-day supply	Not available		✓
Supplies necessary for administration of home infusion drugs	No charge	No charge		✓

Home infusion drugs are self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion, such as an intravenous or intraspinal-infusion.

Certain state-mandated items

Description of Certain State-Mandated Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)	No charge for up to a 30-day supply	Not available		✓
Therapeutics for COVID-19 obtained from Plan Providers	No charge for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Therapeutics for COVID-19 obtained from Non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care)	50% Coinsurance for up to a 30-day supply	Not available		
Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing	No charge for up to a 100-day supply	Not available		✓
Insulin-administration devices: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear)	$10 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Human milk as described in this *EOC*	No charge	Not available		

For drugs related to the treatment of diabetes (for example, insulin), and for continuous insulin delivery devices that use disposable items such as patches or pods, refer to the "Most items" table above. For insulin pumps, refer to the "Durable Medical Equipment ("DME") for home use" table above.

Contraceptive drugs and devices

Description of Contraceptive Drugs and Devices	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
The following hormonal contraceptive items on Tier 1: • Rings • Patches • Oral contraceptives	No charge for up to a 365-day supply	No charge for up to a 365-day supply Availability for mail order varies by item. Talk to your local pharmacy		✓

Description of Contraceptive Drugs and Devices	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
The following contraceptive items on Tier 1: • Spermicide • Sponges • Contraceptive gel	No charge for up to a 100-day supply	Not available		✓
The following hormonal contraceptive items on Tier 2: • Rings • Patches • Oral contraceptives	No charge for up to a 365-day supply	No charge for up to a 365-day supply Availability for mail order varies by item. Talk to your local pharmacy		✓
The following contraceptive items on Tier 2: • Spermicide • Sponges • Contraceptive gel	No charge for up to a 100-day supply	Not available		✓
Emergency contraception	No charge	Not available		✓
Diaphragms, cervical caps, and up to a 30-day supply of condoms	No charge	Not available		✓

Certain preventive items

Description of Certain Preventive Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on our Preventive Services list on our website at **kp.org/prevention** when prescribed by a Plan Provider	No charge for up to a 100-day supply	Not available		✓

Fertility and sexual dysfunction drugs

Description of Fertility and Sexual Dysfunction Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Drugs on Tier 1 prescribed in connection with covered Fertility Services	$10 for up to a 30-day supply	$20 for up to a 100-day supply		✓
Drugs on Tier 2 prescribed in connection with covered Fertility Services	$20 for up to a 30-day supply	$40 for up to a 100-day supply		✓

Description of Fertility and Sexual Dysfunction Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Drugs on Tier 4 prescribed in connection with covered Fertility Services	20% Coinsurance (not to exceed $150) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Drugs on Tier 1 prescribed for sexual dysfunction disorders	50% Coinsurance (not to exceed $50) for up to a 100-day supply	50% Coinsurance (not to exceed $50) for up to a 100-day supply		✓
Drugs on Tier 2 and Tier 4 prescribed for sexual dysfunction disorders	50% Coinsurance (not to exceed $100) for up to a 100-day supply	50% Coinsurance (not to exceed $100) for up to a 100-day supply		✓

Outpatient surgery and outpatient procedures

Description of Outpatient Surgery and Outpatient Procedure Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	$100 per procedure		✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	$15 per procedure		✓

Preventive Services

Description of Preventive Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine physical exams, including well-woman, postpartum follow-up, and preventive exams for Members age 2 and older	No charge		✓
Well-child preventive exams for Members through age 23 months	No charge		✓
Normal series of regularly scheduled preventive prenatal care exams after confirmation of pregnancy	No charge		✓
Immunizations (including the vaccine) administered to you in a Plan Medical Office	No charge		✓

Description of Preventive Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Immunizations (including the vaccine) for COVID-19 administered by Non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care)	50% Coinsurance		
Tuberculosis skin tests	No charge		✓
Screening and counseling Services when provided during a routine physical exam or a well-child preventive exam, such as obesity counseling, routine vision and hearing screenings, alcohol and substance abuse screenings, health education, depression screening, and developmental screenings to diagnose and assess potential developmental delays	No charge		✓
Screening colonoscopies	No charge		✓
Screening flexible sigmoidoscopies	No charge		✓
Routine imaging screenings such as mammograms	No charge		✓
Bone density CT scans	No charge		✓
Bone density DEXA scans	No charge		✓
Routine laboratory tests and screenings, such as cancer screening tests, sexually transmitted infection (“STI”) tests, cholesterol screening tests, and glucose tolerance tests	No charge		✓
Other laboratory screening tests, such as fecal occult blood tests and hepatitis B screening tests	No charge		✓

Prosthetic and orthotic devices

Description of Prosthetic and Orthotic Device Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
External prosthetic and orthotic devices as described in this *EOC*	No charge		✓
Supplemental prosthetic and orthotic devices as described in this *EOC*	No charge		✓

Rehabilitative and habilitative Services

Description of Rehabilitative and Habilitative Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Individual outpatient physical, occupational, and speech therapy	$15 per visit		✓
Group outpatient physical, occupational, and speech therapy	$7 per visit		✓
Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program	$15 per day		✓

Reproductive Health Services

Family planning Services

Description of Family Planning Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Family planning counseling	No charge		✓
Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices (“IUDs”) and office visits related to their insertion, removal, and management when provided to prevent pregnancy	No charge		✓
Sterilization procedures for Members assigned female at birth if performed in an outpatient or ambulatory surgery center or in a hospital operating room	No charge		✓
All other sterilization procedures for Members assigned female at birth	No charge		✓
Sterilization procedures for Members assigned male at birth if performed in an outpatient or ambulatory surgery center or in a hospital operating room	No charge		✓
All other sterilization procedures for Members assigned male at birth	No charge		✓

Abortion and abortion-related Services

Description of abortion and abortion-related Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Surgical abortion	No charge		✓
Outpatient Prescription Drugs, in accord with our drug formulary guidelines	No charge		✓

Description of abortion and abortion-related Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Other abortion-related Services	No charge		✓

Plan Doula services

Description of Plan Doula services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Initial, prenatal, or postpartum visits	No charge		✓
Support during labor and delivery	No charge		✓

Skilled nursing facility care

Description of Skilled Nursing Facility Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Skilled nursing facility Services up to 100 days per benefit period*	No charge		✓

*A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.

Substance use disorder treatment

Description of Substance Use Disorder Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient detoxification	$250 per admission		✓
Individual substance use disorder evaluation and treatment	$15 per visit		✓
Group substance use disorder treatment	$5 per visit		✓
Intensive outpatient and day-treatment programs	No charge		✓
Methadone maintenance treatment	No charge		✓
Residential substance use disorder treatment	No charge		✓

Telehealth visits

Interactive video visits

Description of Interactive Video Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge		✓
Physician Specialist Visits	No charge		✓

Scheduled telephone visits

Description of Scheduled Telephone Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge		✓
Physician Specialist Visits	No charge		✓

Vision Services for Adult Members

Description of Vision Services for Adult Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	No charge		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$15 per visit		✓
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$15 per visit		✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Specialty contact lenses (other than aniridia and aphakia lenses) that will provide a significant improvement in vision not obtainable with eyeglass lenses: either one pair of contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses (up to six months, including fitting and dispensing) in any 24-month period	No charge after optical Allowance applied		

Description of Vision Services for Adult Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Eyeglasses and contact lenses as described in this *EOC*	We provide a $150 Allowance every 24 months		
Replacement lenses if there has been a change in prescription of at least .50 diopter in one or both eyes within 12 months of the initial point of sale of an eyeglass lens or contact lens that we provided an Allowance toward (or otherwise covered)	We provide a $30 Allowance for a single vision eyeglass lens or contact lens, a $45 Allowance for a multifocal or lenticular eyeglass lens		
Low vision devices (including fitting and dispensing)	Not covered		

Vision Services for Pediatric Members

Description of Vision Services for Pediatric Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	No charge		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$15 per visit		✓
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$15 per visit		✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Specialty contact lenses (other than aniridia and aphakia lenses) that will provide a significant improvement in vision not obtainable with eyeglass lenses: either one pair of contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses (up to six months, including fitting and dispensing) in any 24-month period	No charge after optical Allowance applied		
Eyeglasses and contact lenses as described in this *EOC*	We provide a $150 Allowance every 24 months		

Description of Vision Services for Pediatric Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Replacement lenses if there has been a change in prescription of at least .50 diopter in one or both eyes within 12 months of the initial point of sale of an eyeglass lens or contact lens that we provided an Allowance toward (or otherwise covered)	No charge		
Low vision devices (including fitting and dispensing)	Not covered		

CARE Plan

The California Community Assistance, Recovery, and Empowerment ("CARE") Act established a system for individuals with severe mental illness to be evaluated and given a treatment plan developed by a county behavioral health agency ("CARE Plan"). If a Member has a court-approved CARE Plan, we cover the Services required under that plan when provided by Plan Providers or Non-Plan Providers at **no charge**, with the exception of Prescription Drugs. Prescription Drugs required under a court-approved CARE Plan are subject to the same Cost Share as drugs prescribed by Plan Providers, as described in this Cost Share Summary, and are also subject to prior authorization by Health Plan. To inform us that you have a court-approved CARE Plan, please call Member Services.

Health Care Treatment Following Rape or Sexual Assault

As required by state law, for a period of nine months after a Member initiates treatment after a rape or sexual assault, Cost Share for the following Services is **no charge**:

- Emergency Services related to the rape or sexual assault that are received from Plan Providers or Non-Plan Providers
- Related follow-up Services that are received from Plan Providers

Introduction

This *Evidence of Coverage* (*"EOC"*) describes the health care coverage of this Kaiser Permanente Traditional HMO Plan provided under the *Group Agreement* (*"Agreement"*) between Kaiser Foundation Health Plan, Inc. ("Health Plan") and the entity with which Health Plan has entered into the *Agreement* (your "Group").

This *EOC* is part of the *Agreement* between Health Plan and your Group. The *Agreement* contains additional terms such as Premiums, when coverage can change, the effective date of coverage, and the effective date of termination. The *Agreement* must be consulted to determine the exact terms of coverage. A copy of the *Agreement* is available from your Group.

Once enrolled in other coverage made available through Health Plan, that other plan's evidence of coverage cannot be cancelled without cancelling coverage under this *EOC*, unless the change is made during open enrollment or a special enrollment period.

For benefits provided under any other program offered by your Group (for example, workers compensation benefits), refer to your Group's materials.

In this *EOC*, Health Plan is sometimes referred to as "we" or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *EOC*; please see the "Definitions" section for terms you should know.

It is important to familiarize yourself with your coverage by reading this *EOC* completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

About Kaiser Permanente

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY GET HEALTH CARE.

Our medical care program

Kaiser Permanente provides Services directly to our Members through an integrated medical care program. Health Plan, Plan Hospitals, and the Medical Group work together to provide our Members with quality care. Our medical care program gives you access to Covered Benefits, such as routine care with your own personal Plan Physician, hospital Services, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *EOC*. Plus, our health education programs offer you great ways to protect and improve your health.

We provide Covered Benefits to Members using Plan Providers located in your Service Area. You must receive all covered care from Plan Providers inside your Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Covered Services received outside of your Service Area as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section
- COVID-19 Services as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Pharmacy Services," and "Preventive Services" in the "Benefits" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "How to Obtain Services" section
- Hospice care as described under "Hospice Care" in the "Benefits" section

Your Service Area

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), which we call your "Home Region." **The coverage information in this *EOC* applies when you obtain care in the Service Area of your Home Region.** See "Home Region" in the "Definitions" section for the geographic area of your Service Area. When you visit the other California Region, you may receive care as described in "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section.

Term of this *EOC*

This *EOC* is for the period January 1, 2026, through December 31, 2026, unless amended. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended.

Definitions

Some terms have special meaning in this *EOC*. When we use a term with special meaning in only one section of this *EOC*, we define it in that section. The terms in this "Definitions" section have special meaning when capitalized and used in any section of this *EOC*.

Accumulation Period: A period of time no greater than 12 consecutive months for purposes of accumulating amounts toward any deductibles (if applicable), out-of-pocket maximums, and benefit limits. For example, the Accumulation Period may be a calendar year or contract year. The Accumulation Period for this *EOC* is from January 1 through December 31.

Advance Health Care Directive: A legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, see "Advance Directives" in the "Miscellaneous Provisions" section.

Allowance: A specified amount that you can use toward the purchase price of an item. If the price of the items you select exceeds the Allowance, you will pay the amount in excess of the Allowance (and that payment will not apply toward any deductible or out-of-pocket maximum).

Ancillary Coverage: Optional benefits such as acupuncture, chiropractic, or dental coverage that may be available to Members enrolled under this *EOC.* If your plan includes Ancillary Coverage, this coverage will be described in an amendment to this *EOC* or a separate agreement from the issuer of the coverage.

Appropriately Qualified Health Care Professional: A Health Care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Approved Clinical Trial: A phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another Life-Threatening disease or condition that meets at least one of the following:

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
  - The National Institutes of Health
  - The federal Centers for Disease Control and Prevention
  - The Agency for Healthcare Research and Quality
  - The federal Centers for Medicare and Medicaid Services
  - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs
  - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
  - One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
    - The United States Department of Veterans Affairs
    - The United States Department of Defense
    - The United States Department of Energy
- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration
- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration

Behavioral Health Treatment for Autism Spectrum Disorder: Professional Services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of a person with autism spectrum disorder (or treat mental health conditions other than autism spectrum disorder when this treatment is clinically indicated) that meet the following criteria:

- The treatment is prescribed by a Plan Physician, or is developed by a Plan Provider who is a psychologist
- The treatment is administered by a Plan Provider who is a qualified autism service provider, qualified autism service professional, or qualified autism service paraprofessional, as defined in California Health and Safety Code section 1374.73(c)

Charges: "Charges" means the following:

- For Services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members
- For Services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)
- For air ambulance Services received from Non-Plan Providers when you have an Emergency Medical Condition or Psychiatric Emergency Medical Condition, the amount required to be paid by Health Plan pursuant to federal law
- For other Emergency Services and Care received from Non-Plan Providers (including Post-Stabilization Care that constitutes Emergency Services and Care under federal law), the amount required to be paid by Health Plan pursuant to state law, when it is applicable, or federal law
- For all other Services received from Non-Plan Providers (including Post-Stabilization Services that are not Emergency Services and Care under federal law), the amount (1) required to be paid pursuant to state law, when it is applicable, or federal law, or (2) in the event that neither state or federal law prohibiting balance billing apply, then the amount agreed to by the Non-Plan Provider and Health Plan or, absent such an agreement, the usual, customary and reasonable rate for those services as determined by Health Plan based on objective criteria
- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts your Cost Share from its payment, the amount Kaiser Permanente would have paid if it did not subtract your Cost Share

Cigna Healthcare PPO Network: The Cigna Healthcare PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of a shared administration network arrangement called Cigna Healthcare PPO for Shared Administration. Cigna Healthcare is an independent company and not affiliated with Kaiser Foundation Health Plan, Inc., and its subsidiary health plans. Access to the Cigna Healthcare PPO Network is available through Cigna Healthcare's contractual relationship with the Kaiser Permanente health plans. The Cigna Healthcare PPO Network is provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company. The Cigna Healthcare name, logo, and other marks are owned by Cigna Intellectual Property, Inc.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service under this *EOC*.

Copayment: A specific dollar amount that you must pay when you receive a covered Service under this *EOC*. Note: The dollar amount of the Copayment can be $0 (no charge).

Cost Share: The amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Similarly, if your coverage includes a Drug Deductible, and you receive Services that are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Covered Benefits: Those Medically Necessary Services and supplies that you are entitled to receive under a group agreement and which are described in this *EOC* or under California health plan law.

Dependent: A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

Disclosure Form ("DF"): A summary of coverage for prospective Members. For some products, the DF is combined with the evidence of coverage.

Drug Deductible: The amount you must pay under this *EOC* in the Accumulation Period for certain drugs, supplies, and supplements before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Refer to the "Cost Share Summary" section to learn whether your coverage includes a Drug Deductible, the Services that are subject to the Drug Deductible, and the Drug Deductible amount.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of

immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency Services and Care: Either of the following:

- Medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, within the scope of that person's license, if necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility
- An additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition within the capability of the facility

***EOC*:** This *Evidence of Coverage* document, including any amendments, which describes the health care coverage of "Kaiser Permanente Traditional HMO Plan" under Health Plan's *Agreement* with your Group.

Evidence of Coverage: Any certificate, agreement, contract, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is entitled.

Experimental Services: Drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

Family: A Subscriber and all of their Dependents.

Group: The entity with which Health Plan has entered into the *Agreement* that includes this *EOC*.

Health Care Provider: Any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health care services.

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. Health Plan is a health care service plan licensed to offer health care coverage by the Department of Managed Health Care.

Home Region: The Region where you enrolled (either the Northern California Region or the Southern California Region). Note: We may expand the Service Area of your Home Region at any time by giving written notice to your Group. ZIP codes are subject to change by the U.S. Postal Service.

The ZIP codes below for each county are in the Service Area of your Home Region:

- Imperial County: 92274-75
- Kern County: 93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93249-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-14, 93380, 93383-90, 93501-02, 93504-05, 93518-19, 93531, 93536, 93560-61, 93581
- Los Angeles County: 90001-84, 90086-89, 90091, 90093-96, 90099, 90134, 90140, 90189, 90201-02, 90205, 90209-13, 90220-24, 90230-32, 90239-42, 90245, 90247-51, 90254-55, 90260, 90262-67, 90270, 90272, 90274-75, 90277-78, 90280, 90290-96, 90301-12, 90401-11, 90501-10, 90601-10, 90623, 90630-31, 90637-40, 90650-52, 90660-62, 90670-71, 90701-03, 90706-07, 90710-17, 90723, 90731-34, 90744-49, 90755, 90801-10, 90813-15, 90822, 90831-33, 90840, 90842, 90844, 90846-48, 90853, 90895, 91001, 91003, 91006-12, 91016-17, 91020-21, 91023-25, 91030-31, 91040-43, 91046, 91066, 91077, 91101-10, 91114-18, 91121, 91123-26, 91129, 91182, 91184-85, 91188-89, 91199, 91201-10, 91214, 91221-22, 91224-26, 91301-11, 91313, 91316, 91321-22, 91324-28, 91330-31, 91333-35, 91337, 91340-46, 91350-57, 91361-62, 91364-65, 91367, 91371-72, 91376, 91380-87, 91390, 91392-96, 91401-13, 91416, 91423, 91426, 91436, 91470, 91482, 91499, 91501-08, 91510, 91521-23, 91601-10, 91614-18, 91702, 91706, 91711, 91714-16, 91722-24, 91731-35, 91740-41, 91744-50, 91754-56, 91759, 91765-73, 91775-76, 91778, 91780, 91788-93, 91801-04, 91896, 91899, 93243, 93510, 93532, 93534-36, 93539, 93543-44, 93550-53, 93560, 93563, 93584, 93586, 93590-91, 93599
- Orange County (whole county): 90620-24, 90630-33, 90638, 90680, 90720-21, 90740, 90742-43, 92602-07, 92609-10, 92612, 92614-20, 92623-30, 92637, 92646-63, 92672-79, 92683-85, 92688, 92690-94, 92697-98, 92701-08, 92711, 92728, 92735, 92780-82, 92799, 92801-09, 92811-12, 92814-17, 92821-23, 92825, 92831-38, 92840-46, 92856-57, 92859, 92861-71, 92885-87, 92899
- Riverside County: 91752, 92028, 92201-03, 92210-11, 92220, 92223, 92230, 92234-36, 92240-41, 92247-48, 92253-55, 92258, 92260-64, 92270, 92274, 92276, 92282, 92320, 92324, 92373, 92399, 92501-09, 92513-14, 92516-19, 92521-22, 92530-32,

92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92589-93, 92595-96, 92599, 92860, 92877-83

- San Bernardino County: 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-59, 91761-64, 91766, 91784-86, 92252, 92256, 92268, 92277-78, 92284-86, 92305, 92307-08, 92313-18, 92321-22, 92324-25, 92329, 92331, 92333-37, 92339-41, 92344-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-95, 92397, 92399, 92401-08, 92410-11, 92413, 92415, 92418, 92423, 92427, 92880
- San Diego County: 91901-03, 91908-17, 91921, 91931-33, 91935, 91941-46, 91950-51, 91962-63, 91976-80, 91987, 92003, 92007-11, 92013-14, 92018-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-61, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92081-86, 92088, 92091-93, 92096, 92101-24, 92126-32, 92134-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-61, 92163, 92165-79, 92182, 92186-87, 92191-93, 92195-99
- Tulare County: 93238, 93261
- Ventura County: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93001-07, 93009-12, 93015-16, 93020-22, 93030-36, 93040-44, 93060-66, 93094, 93099, 93252

For each ZIP code listed for a county, your Service Area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside your Service Area unless that other county is listed above and that ZIP code is also listed for that other county.

If you have a question about whether a ZIP code is in your Service Area, please call Member Services.

Independent Medical Review ("IMR"): A review of your health plans denial, modification, or delay of your request for health care services or treatment. The review is provided by the Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by your health plan related to medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. Your health plan must pay for the services if an IMR decides you need it.

Infertility: A condition or status characterized by any of the following:

- A Plan Physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition does not prevent testing and diagnosis of infertility before the 12-month or 6-month period to establish infertility in the third bullet
- A person's inability to reproduce either as an individual or with their partner without medical intervention
- The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. For purposes of this section, "regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility

Investigational Services: Those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress and all of the following are true:

- Testing is not complete
- The efficacy and safety of such services in human subjects are not yet established
- The service is not in wide usage

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

Kaiser Permanente State: California, Colorado, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington.

Life-Threatening: Either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival

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

Medically Necessary: A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of care, including generally accepted standards of Mental Health or Substance Use Disorder care

- Clinically appropriate in terms of type, frequency, extent, site, and duration
- Not primarily for the economic benefit of the health care service plan and Members or for the convenience of the patient, treating physician, or other Health Care Provider

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).

Member: A Subscriber or Dependent of a Subscriber, who has enrolled in this Kaiser Permanente Traditional HMO Plan, and whose coverage is active.

Mental Health or Substance Use Disorder: A mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Non-Physician Specialist Visits: Consultations, evaluations, and treatment by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists). For Services described under "Dental and Orthodontic Services" in the "Benefits" section, non-physician specialists include dentists and orthodontists.

Non–Plan Hospital: A hospital other than a Plan Hospital.

Non–Plan Pharmacy: A pharmacy other than a Plan Pharmacy.

Non–Plan Physician: A physician other than a Plan Physician.

Non–Plan Provider: A provider other than a Plan Provider.

Non–Plan Psychiatrist: A psychiatrist who is not a Plan Physician.

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:

- You are temporarily outside your Service Area
- A reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to your Service Area

Outpatient Prescription Drug: A self-administered drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or mail order pharmacy, requires a prescription, and has not been provided for use on an inpatient basis.

Physician Specialist Visits: Consultations, evaluations, and treatment by physician specialists, including personal Plan Physicians who are not Primary Care Physicians.

Plan Deductible: The amount you must pay under this *EOC* in the Accumulation Period for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Refer to the "Cost Share Summary" section to learn whether your coverage includes a Plan Deductible, the Services that are subject to the Plan Deductible, and the Plan Deductible amount.

Plan Doula: A contracted birth worker who provides physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth.

Plan Facility: Any facility listed in the Provider Directory on our website at **kp.org/facilities**. Plan Facilities include Plan Hospitals, Plan Medical Offices, and other facilities that we designate in the directory. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call Member Services.

Plan Hospital: Any hospital listed in the Provider Directory on our website at **kp.org/facilities**. In the directory, some Plan Hospitals are listed as Kaiser Permanente Medical Centers. The directory is updated periodically. The availability of Plan Hospitals may change. If you have questions, please call Member Services.

Plan Medical Office: Any medical office listed in the Provider Directory on our website at **kp.org/facilities**. In the directory, Kaiser Permanente Medical Centers may include Plan Medical Offices. The directory is updated periodically. The availability of Plan Medical Offices may change. If you have questions, please call Member Services.

Plan Optical Sales Office: An optical sales office owned and operated by Kaiser Permanente or another optical sales office that we designate. Refer to the Provider Directory on our website at **kp.org/facilities** for locations of Plan Optical Sales Offices. In the directory, Plan Optical Sales Offices may be called "Vision Essentials." The directory is updated periodically. The availability of Plan Optical Sales Offices may change. If you have questions, please call Member Services.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Out-of-Pocket Maximum: The total amount of Cost Share you must pay under this *EOC* in the Accumulation Period for certain covered Services that you receive in the same Accumulation Period. Refer to the "Cost Share Summary" section to find your Plan Out-of-Pocket Maximum amount and to learn which Services apply to the Plan Out-of-Pocket Maximum.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Refer to the Provider Directory on our website at **kp.org/facilities** for locations of Plan Pharmacies. The directory is updated periodically. The availability of Plan Pharmacies may change. If you have questions, please call Member Services.

Plan Physician: Any licensed physician who is a partner or employee of the Medical Group, or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other Health Care Provider that Health Plan designates as a Plan Provider.

Plan Skilled Nursing Facility: A Skilled Nursing Facility approved by Health Plan.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition or Psychiatric Emergency Medical Condition that you receive in a hospital (including the emergency department), an independent freestanding emergency department, or a skilled nursing facility after your treating physician determines that this condition is Stabilized. Post-Stabilization Care also includes durable medical equipment covered under this *EOC*, if it is Medically Necessary after discharge from an emergency department and related to the same Emergency Medical Condition. For more information about durable medical equipment covered under this *EOC*, see "Durable Medical Equipment ("DME") for Home Use" in the "Benefits" section.

Premiums: The periodic amounts that your Group is responsible for paying for your membership under this *EOC,* except that you are responsible for paying Premiums if you have Cal-COBRA coverage. "Full Premiums" means 100 percent of Premiums for all of the coverage issued to each enrolled Member, as set forth in the "Premiums" section of Health Plan's *Agreement* with your Group.

Prescription Drug: A drug approved by the federal Food and Drug Administration ("FDA") for sale to consumers that requires a prescription and is not provided for use on an inpatient basis. The term "drug" or "prescription drug" includes the following:

- Disposable devices that are medically necessary for the administration of a covered prescription drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs
- Syringes for self-injectable prescription drugs that are not dispensed in pre-filled syringes
- Drugs, devices, and FDA-approved products covered under the prescription drug benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products
- Any vaccines or other health care benefits covered under "Outpatient Pharmacy Services" in the *EOC* for this Kaiser Permanente Traditional HMO Plan

Preventive Services: Covered Services listed on our website at **kp.org/prevention** that prevent or detect illness and do one or more of the following:

- Protect against disease and disability or further progression of a disease
- Detect disease in its earliest stages before noticeable symptoms develop

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Refer to the Provider Directory on our website at **kp.org/facilities** for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call Member Services.

Primary Care Visits: Evaluations and treatment provided by Primary Care Physicians and primary care Plan Providers who are not physicians (such as nurse practitioners).

Provider Directory: A directory of Plan Physicians and Plan Facilities in your Service Area. This directory is available on our website at **kp.org/facilities**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call Member Services.

Psychiatric Emergency Medical Condition: A mental disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 of each year and are currently the District of Columbia and parts of Northern California, Southern California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For the current list of Region locations, please visit our website at **kp.org** or call Member Services.

Seriously Debilitating: Diseases or conditions that cause major irreversible morbidity.

Service Area: The geographic area designated by the plan within which a plan shall provide health care services.

Services: Health care services or items ("health care" includes physical health care, mental health care, and substance use disorder treatment), and Behavioral Health Treatment for Autism Spectrum Disorder covered under "Mental Health Services" in the "Benefits" section.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Spouse: The person to whom the Subscriber is legally married under applicable law. For the purposes of this *EOC*, the term "Spouse" includes the Subscriber's domestic partner. "Domestic partners" are two people who are registered and legally recognized as domestic partners by California (if your Group allows enrollment of domestic partners not legally recognized as domestic partners by California, "Spouse" also includes the Subscriber's domestic partner who meets your Group's eligibility requirements for domestic partners).

Stabilize: To provide the medical treatment of the Emergency Medical Condition or Psychiatric Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant person who is having contractions, when there is inadequate time to safely transfer them to another hospital before delivery (or the transfer may pose a threat to the health or safety of the pregnant person or unborn child), "Stabilize" means to deliver (including the placenta).

Standard Fertility Preservation Services: Procedures that are consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Subscriber: A Member who is eligible for membership on their own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

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

Telehealth Visits: Interactive video visits and scheduled telephone visits between you and your provider.

Trans-Inclusive Health Care: Comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex; honors an individual's personal bodily autonomy; does not make assumptions about an individual's gender; accepts gender fluidity and nontraditional gender presentation; and treats everyone with compassion, understanding, and respect.

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition or Psychiatric Emergency Medical Condition.

Premiums, Eligibility, and Enrollment

Premiums

Your Group is responsible for paying Full Premiums, except that you are responsible for paying Full Premiums as described in the "Continuation of Membership" section if you have Cal-COBRA coverage under this *EOC*. If you are responsible for any contribution to the Premiums that your Group pays, your Group will tell you the amount, when Premiums are effective, and how to pay your Group (through payroll deduction, for example).

Who Is Eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this "Who Is Eligible" section, including your Group's eligibility requirements and our Service Area eligibility requirements.

Group eligibility requirements

You must meet your Group's eligibility requirements, such as the minimum number of hours that employees must work. Your Group is required to inform Subscribers of its eligibility requirements.

Service Area eligibility requirements

Subscribers must live or work inside their Service Area at the time they enroll. If after enrollment the Subscriber no longer lives or works inside their Service Area, the Subscriber can continue membership unless (1) they live inside or move to the Service Area of another Region and do not work inside their Service Area, or (2) your Group does not allow continued enrollment of Subscribers who do not live or work inside their Service Area.

Dependent children of the Subscriber or of the Subscriber's Spouse may live anywhere inside or outside their Service Area. Other Dependents may live anywhere, except that they are not eligible to enroll or to continue enrollment if they live in or move to the Service Area of another Region.

If you are not eligible to continue enrollment because you live in or move to the Service Area of another Region, please contact your Group to learn about your Group health care options:

- **Regions outside California**. You may be able to enroll in the Service Area of another Region if there is an agreement between your Group and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*
- **Northern California Region's Service Area**. Your Group may have an arrangement with us that permits membership in the Northern California Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*. All terms and conditions in your application for enrollment in the Southern California Region, including the Arbitration Agreement, will continue to apply if the Subscriber does not submit a new enrollment form

For more information about the Service Areas of the other Regions, please call Member Services.

Eligibility as a Subscriber

You may be eligible to enroll and continue enrollment as a Subscriber if you are:

- An employee of your Group
- A proprietor or partner of your Group
- Otherwise entitled to coverage under a trust agreement, retirement benefit program, or employment contract (unless the Internal Revenue Service considers you self-employed)

Eligibility as a Dependent

Enrolling a Dependent

Dependent eligibility is subject to your Group's eligibility requirements, which are not described in this *EOC*. You can obtain your Group's eligibility requirements directly from your Group. If you are a Subscriber under this *EOC* and if your Group allows enrollment of Dependents, Health Plan allows the following persons to enroll as your Dependents under this *EOC*:

- Your Spouse
- Your or your Spouse's Dependent children, who meet the requirements described under "Age limit of Dependent children," if they are any of the following:
  - biological children
  - stepchildren
  - adopted children
  - children placed with you for adoption
  - foster children if you or your Spouse have the legal authority to direct their care
  - children for whom you or your Spouse is the court-appointed guardian (or was when the child reached age 18)
- Children whose parent is a Dependent child under your family coverage (including adopted children and children placed with your Dependent child for adoption or foster care), if they meet all of the following requirements:
  - they are not married and do not have a domestic partner (for the purposes of this requirement only, "domestic partner" means someone who is registered and legally recognized as a domestic partner by California)
  - they meet the requirements described under "Age limit of Dependent children"
  - they receive all of their support and maintenance from you or your Spouse
  - they permanently reside with you or your Spouse

If you have a baby
If you have a baby while enrolled under this *EOC*, the baby is not automatically enrolled in this plan. The Subscriber must request enrollment of the baby as described under "Special enrollment" in the "How to Enroll and When Coverage Begins" section below. If the Subscriber does not request enrollment within this special enrollment period, the baby will only be covered under this plan for 31 days (including the date of birth).

Age limit of Dependent children
Children must be under age 26 as of the effective date of this *EOC* to enroll as a Dependent under your plan.

Dependent children are eligible to remain on the plan through the end of the month in which they reach the age limit.

Dependent children of the Subscriber or Spouse (including adopted children and children placed with you for adoption or foster care) who reach the age limit may continue coverage under this *EOC* if all of the following conditions are met:

- They meet all requirements to be a Dependent except for the age limit
- Your Group permits enrollment of Dependents
- They are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred before they reached the age limit for Dependents
- They receive 50 percent or more of their support and maintenance from you or your Spouse
- If requested, you give us proof of their incapacity and dependency within 60 days after receiving our request (see "Overage Dependent certification" below in this "Eligibility as a Dependent" section)

Overage Dependent certification
Proof may be required for a Dependent to be eligible to continue coverage as an overage Dependent. If we request it, the Subscriber must provide us documentation of the dependent's incapacity and dependency as follows:

- If the child is a Member, we will send the Subscriber a notice of the Dependent's membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. The Dependent's membership will terminate as described in our notice unless the Subscriber provides us documentation of the Dependent's incapacity and dependency within 60 days of receipt of our notice and we determine that the Dependent is eligible as an overage dependent. If the Subscriber provides us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that the Dependent does not meet the eligibility requirements as an overage dependent, we will notify the Subscriber that the Dependent is not eligible and let the Subscriber know the membership termination date. If we determine that the Dependent is eligible as an overage dependent, there will be no lapse in coverage. Also, starting two years after the date that the Dependent reached the age limit, the Subscriber must provide us documentation of the Dependent's incapacity and dependency annually within 60 days after we request it so that we can determine if the Dependent continues to be eligible as an overage dependent
- If the child is not a Member because you are changing coverage, you must give us proof, within 60 days after we request it, of the child's incapacity and dependency as well as proof of the child's coverage under your prior coverage. In the future, you must provide proof of the child's continued incapacity and dependency within 60 days after you receive our request, but not more frequently than annually

If the Subscriber is enrolled under a Kaiser Permanente Medicare plan
The dependent eligibility rules described in the "Eligibility as a Dependent" section also apply if you are a subscriber under a Kaiser Permanente Medicare plan offered by your Group (please ask your Group about your membership options). All of your dependents who are enrolled under this or any other non-Medicare evidence of coverage offered by your Group must be enrolled under the same non-Medicare evidence of coverage. A "non-Medicare" evidence of coverage is one that does not require members to have Medicare.

Persons barred from enrolling
You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

Members with Medicare and retirees
This *EOC* is not intended for most Medicare beneficiaries and some Groups do not offer coverage to retirees. If, during the term of this *EOC*, you are (or become) eligible for Medicare or you retire, please ask your Group about your membership options as follows:

- If a Subscriber who has Medicare Part B retires and the Subscriber's Group has a Kaiser Permanente Senior Advantage plan for retirees, the Subscriber should enroll in the plan if eligible

- If the Subscriber has dependents who have Medicare and your Group has a Kaiser Permanente Senior Advantage plan (or of one our other plans that require members to have Medicare), the Subscriber may be able to enroll them as dependents under that plan
- If the Subscriber retires and your Group does not offer coverage to retirees, you may be eligible to continue membership as described in the "Continuation of Membership" section
- If federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary, your coverage under this *EOC* will be the same as it would be if you had not become eligible for Medicare. However, you may also be eligible to enroll in Kaiser Permanente Senior Advantage through your Group if you have Medicare Part B
- If you are (or become) eligible for Medicare and are in a class of beneficiaries for which your Group's health care coverage is secondary to Medicare, you should consider enrollment in Kaiser Permanente Senior Advantage through your Group if you are eligible
- If none of the above applies to you and you are eligible for Medicare or you retire, please ask your Group about your membership options

Note: If you are enrolled in a Medicare plan and lose Medicare eligibility, you may be able to enroll under this *EOC* if permitted by your Group (please ask your Group for details).

When Medicare is primary

Your Group's Premiums may increase if you are (or become) eligible for Medicare Part A or B as primary coverage, and you are not enrolled through your Group in Kaiser Permanente Senior Advantage for any reason (even if you are not eligible to enroll or the plan is not available to you).

When Medicare is secondary

Medicare is the primary coverage except when federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary. Members who have Medicare when Medicare is secondary by law are subject to the same Premiums and receive the same benefits as Members who are under age 65 and do not have Medicare. In addition, any such Member for whom Medicare is secondary by law and who meets the eligibility requirements for the Kaiser Permanente Senior Advantage plan applicable when Medicare is secondary may also enroll in that plan if it is available. These Members receive the benefits and coverage described in this *EOC* and the Kaiser Permanente Senior Advantage evidence of coverage applicable when Medicare is secondary.

Medicare late enrollment penalties

If you become eligible for Medicare Part B and do not enroll, Medicare may require you to pay a late enrollment penalty if you later enroll in Medicare Part B. However, if you delay enrollment in Part B because you or your spouse are still working and have coverage through an employer group health plan, you may not have to pay the penalty. Also, if you are (or become) eligible for Medicare and go without creditable prescription drug coverage (drug coverage that is at least as good as the standard Medicare Part D prescription drug coverage) for a continuous period of 63 days or more, you may have to pay a late enrollment penalty if you later sign up for Medicare prescription drug coverage. If you are (or become) eligible for Medicare, your Group is responsible for informing you about whether your drug coverage under this *EOC* is creditable prescription drug coverage at the times required by the Centers for Medicare & Medicaid Services and upon your request.

How to Enroll and When Coverage Begins

Your Group is required to inform you when you are eligible to enroll and what your effective date of coverage is. If you are eligible to enroll as described under "Who Is Eligible" in this "Premiums, Eligibility, and Enrollment" section, enrollment is permitted as described below and membership begins at the beginning (12:00 a.m.) of the effective date of coverage indicated below, except that your Group may have additional requirements, which allow enrollment in other situations.

If you are eligible to be a Dependent under this *EOC* but the subscriber in your family is enrolled under a Kaiser Permanente Senior Advantage evidence of coverage offered by your Group, the rules for enrollment of Dependents in this "How to Enroll and When Coverage Begins" section apply, not the rules for enrollment of dependents in the subscriber's evidence of coverage.

New employees

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Health Plan–approved enrollment application to your Group within 31 days.

Effective date of coverage

The effective date of coverage for new employees and their eligible family Dependents is determined by your

Group in accord with waiting period requirements in state and federal law. Your Group is required to inform the Subscriber of the date your membership becomes effective. For example, if the hire date of an otherwise-eligible employee is January 19, the waiting period begins on January 19 and the effective date of coverage cannot be any later than April 19. Note: If the effective date of your Group's coverage is always on the first day of the month, in this example the effective date cannot be any later than April 1.

Open enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan–approved enrollment application to your Group during your Group's open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the effective date of coverage.

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

- You become eligible because you experience a qualifying event (sometimes called a "triggering event") as described in this "Special enrollment" section
- You did not enroll in any coverage offered by your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. The effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application from the Subscriber

Special enrollment due to new Dependents

You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, within 30 days after marriage, establishment of domestic partnership, birth, adoption, placement for adoption, or placement for foster care by submitting to your Group a Health Plan–approved enrollment application.

The effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber. Enrollments of newly acquired Dependent children are effective as follows:

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

Special enrollment due to loss of other coverage

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, if all of the following are true:

- The Subscriber or at least one of the Dependents had other coverage when they previously declined all coverage through your Group
- The loss of the other coverage is due to one of the following:
  - ♦ exhaustion of COBRA coverage
  - ♦ termination of employer contributions for non-COBRA coverage
  - ♦ loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, moving out of the plan's Service Area, reaching the age limit for dependent children, or the subscriber's death, termination of employment, or reduction in hours of employment
  - ♦ loss of eligibility (but not termination for cause) for coverage through Covered California, Medicaid coverage (known as Medi-Cal in California), Children's Health Insurance Program coverage, or Medi-Cal Access Program coverage
  - ♦ reaching a lifetime maximum on all benefits

Note: If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, only one of you must meet the requirements stated above.

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 30 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for coverage through Covered California, Medicaid, Children's Health Insurance Program, or Medi-Cal Access Program coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Special enrollment due to court or administrative order
Within 30 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved enrollment or change of enrollment application.

The effective date of coverage resulting from a court or administrative order is the first of the month following the date we receive the enrollment request, unless your Group specifies a different effective date (if your Group specifies a different effective date, the effective date cannot be earlier than the date of the order).

Special enrollment due to eligibility for premium assistance
You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, if you or a dependent become eligible for premium assistance through the Medi-Cal program. Premium assistance is when the Medi-Cal program pays all or part of premiums for employer group coverage for a Medi-Cal beneficiary. To request enrollment in your Group's health care coverage, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 60 days after you or a dependent become eligible for premium assistance. Please contact the California Department of Health Care Services to find out if premium assistance is available and the eligibility requirements.

Special enrollment due to reemployment after military service
If you terminated your health care coverage because you were called to active duty in the military service, you may be able to reenroll in your Group's health plan if required by state or federal law. Please ask your Group for more information.

Other special enrollment events
You may enroll as a Subscriber (along with any eligible Dependents) if you or your Dependents were not previously enrolled, and existing Subscribers may add eligible Dependents not previously enrolled, if any of the following are true:

- You lose employment for a reason other than gross misconduct
- Your employment hours are reduced
- You are a Dependent of someone who becomes entitled to Medicare
- You become divorced or legally separated
- You are a Dependent of someone who dies
- A Health Benefit Exchange (such as Covered California) determines that one of the following occurred because of misconduct on the part of a non-Exchange entity that provided enrollment assistance or conducted enrollment activities:
  - ♦ a qualified individual was not enrolled in a qualified health plan
  - ♦ a qualified individual was not enrolled in the qualified health plan that the individual selected
  - ♦ a qualified individual is eligible for, but is not receiving, advance payments of the premium tax credit or cost share reductions

To request special enrollment, you must submit a Health Plan-approved enrollment application to your Group within 30 days after loss of other coverage. You may be required to provide documentation that you have experienced a qualifying event. Membership becomes effective either on the first day of the next month (for applications that are received by the fifteenth day of a month) or on the first day of the month following the next month (for applications that are received after the fifteenth day of a month).

Note: If you are enrolling as a Subscriber along with at least one eligible Dependent, only one of you must meet one of the requirements stated above.

How to Obtain Services

As a Member, you are selecting our medical care program to provide your health care. You must receive all Covered Benefits from Plan Providers inside your Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Services" section
- Covered Services received outside of your Service Area as described under "Receiving Care Outside of Your Home Region" in this "How to Obtain Services" section
- COVID-19 Services as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Pharmacy Services," and "Preventive Services" in the "Benefits" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits" section

- Emergency Services and Care, Post-Stabilization Care, and Out-of-Area Urgent Care as described in this "How to Obtain Services" section
- Hospice care as described under "Hospice Care" in the "Benefits" section

Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital Services, laboratory and pharmacy Services, Emergency Services and Care, Urgent Care, and other benefits described in this *EOC*.

Routine Care

If you need the following Services, you should schedule an appointment:

- Preventive Services
- Periodic follow-up care (regularly scheduled follow-up care, such as visits to monitor a chronic condition)
- Other care that is not Urgent Care

To request a non-urgent appointment, you can call your local Plan Facility or request the appointment online. For appointment phone numbers, refer to our Provider Directory or call Member Services. To request an appointment online, go to our website at **kp.org**.

Urgent Care

Inside your Service Area

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition or Psychiatric Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For appointment and advice phone numbers, refer to our Provider Directory or call Member Services.

Out-of-Area Urgent Care

If you need Urgent Care due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), we cover Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health from a Non–Plan Provider if all of the following are true:

- You receive the Services from Non–Plan Providers while you are temporarily outside your Service Area
- A reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to your Service Area

You do not need prior authorization for Out-of-Area Urgent Care. We cover Out-of-Area Urgent Care you receive from Non–Plan Providers if the Services would have been covered under this *EOC* if you had received them from Plan Providers.

To obtain follow-up care from a Plan Provider, call the appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call Member Services. We do not cover follow-up care from Non–Plan Providers after you no longer need Urgent Care, except for durable medical equipment covered under this *EOC*. For more information about durable medical equipment covered under this *EOC*, see "Durable Medical Equipment ("DME") for Home Use" in the "Benefits" section. If you require durable medical equipment related to your Urgent Care after receiving Out-of-Area Urgent Care, your provider must obtain prior authorization as described under "Getting a Referral" in the "How to Obtain Services" section.

Emergency Services

If you have an Emergency Medical Condition or Psychiatric Emergency Medical Condition, call 911 (where available) or go to the nearest emergency department. If you are experiencing a mental health crisis, you can also call or text 988 to be connected to a trained crisis counselor. You do not need prior authorization for Emergency Services and Care. When you have an Emergency Medical Condition or Psychiatric Emergency Medical Condition, we cover Emergency Services and Care you receive from Plan Providers or Non–Plan Providers anywhere in the world.

Emergency Services and Care are available from Plan Hospital emergency departments 24 hours a day, seven days a week.

Post-Stabilization Care

When you receive Post-Stabilization Care from a Non-Plan Provider inside of California, or from a Cigna Healthcare PPO Network facility outside of a Kaiser Permanente State

When you receive Emergency Services and Care, we cover Post-Stabilization Care from a Non–Plan Provider only if prior authorization for the care is obtained as described below, or if otherwise required by applicable law ("prior authorization" means that the Services must be approved in advance).

- **Post-Stabilization Care authorization at a Cigna Healthcare PPO Network facility outside of a Kaiser Permanente State:** If you are outside of a Kaiser Permanente state and you were treated at a Cigna Healthcare PPO Network facility for an

Emergency Medical Condition or Psychiatric Emergency Medical Condition, Cigna Payer Solutions is responsible for authorizing any Post-Stabilization Care

- **Post-Stabilization Care authorization from other Non-Plan Providers (including Cigna Healthcare PPO Network facilities inside a Kaiser Permanente State):** To request prior authorization, the Non–Plan Provider must call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card *before* you receive the care. We will discuss your condition with the Non–Plan Provider. If we determine that you require Post-Stabilization Care and that this care is part of your covered benefits, we will authorize your care from the Non–Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated Non–Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered

  Be sure to ask the Non–Plan Provider to tell you what care (including any transportation) we have authorized because we will not cover Post-Stabilization Care or related transportation provided by Non–Plan Providers that has not been authorized. If you receive care from a Non–Plan Provider that we have not authorized, you may have to pay the full cost of that care. If you are admitted to a Non–Plan Hospital or independent freestanding emergency department, please notify us as soon as possible by calling **1-800-225-8883** or the notification phone number on your ID card

When you receive Post-Stabilization Care from a Non-Plan Provider that is not a Cigna Healthcare PPO Network provider outside of California

After you receive Emergency Services and Care from Non-Plan Providers and your condition is Stabilized, Post-Stabilization Care is considered Emergency Services and Care under federal law if either of the following are true:

- Your treating physician determines that you are not able to travel using nonemergency transportation to an available Plan Provider located within a reasonable travel distance, taking into account your medical condition; or
- Your treating physician, using appropriate medical judgment, determines that you are not in a condition to receive, and/or to provide consent to, the Non-Plan Provider's notice and consent form, in accordance with applicable state informed consent law

If the Post-Stabilization Care is considered Emergency Services and Care under the criteria above, prior authorization for Post-Stabilization Care at a Non-Plan Provider will not be required.

If the Post-Stabilization Care is not considered Emergency Services and Care, the Services are not covered unless you have received prior authorization from Health Plan as described under "Post-Stabilization Care authorization from other Non-Plan Providers (including Cigna Healthcare PPO Network facilities inside a Kaiser Permanente State)" above. Non-Plan Providers outside of California may provide notice and seek your consent to waive your balance billing protections under the federal No Surprises Act, if such consent is permissible under applicable state informed consent law. If you consent to waive your balance billing protections and receive Services from the Non-Plan Provider, you will have to pay the full cost of the Services.

Not Sure What Kind of Care You Need?

Sometimes it's difficult to know what kind of care you need, so we have licensed health care professionals available to assist you by phone 24 hours a day, seven days a week. Here are some of the ways they can help you:

- They can answer questions about a health concern, and instruct you on self-care at home if appropriate
- They can advise you about whether you should get medical care, and how and where to get care (for example, if you are not sure whether your condition is an Emergency Medical Condition or Psychiatric Emergency Medical Condition, they can help you decide whether you need Emergency Services and Care or Urgent Care, and how and where to get that care)
- They can tell you what to do if you need care and a Plan Medical Office is closed or you are outside your Service Area

You can reach one of these licensed health care professionals by calling the appointment or advice phone number (for phone numbers, refer to our Provider Directory or call Member Services). When you call, a trained support person may ask you questions to help determine how to direct your call.

Your Personal Plan Physician

Personal Plan Physicians provide primary care and play an important role in coordinating care, including hospital stays and referrals to specialists.

We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal Plan Physicians. However, if you choose a specialist who is not designated as a Primary Care Physician as your personal Plan Physician, the Cost Share for a Physician Specialist Visit will apply to all visits with the specialist except for routine preventive visits listed under "Preventive Services" in the "Benefits" section.

To learn how to select or change to a different personal Plan Physician, visit our website at **kp.org** or call Member Services. Refer to our Provider Directory for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call Member Services. You can change your personal Plan Physician at any time for any reason.

Getting a Referral

Referrals to Plan Providers

A Plan Physician must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, dermatology, and physical, occupational, and speech therapies. Also, a Plan Physician must refer you before you can get Behavioral Health Treatment for Autism Spectrum Disorder covered under "Mental Health Services" in the "Benefits" section. However, you do not need a referral or prior authorization to receive most care from any of the following Plan Providers:

- Your personal Plan Physician
- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, mental health Services, substance use disorder treatment, and obstetrics/gynecology

A Plan Physician must refer you before you can get care from a specialist in urology except that you do not need a referral to receive Services related to sexual or reproductive health, such as a vasectomy.

Although a referral or prior authorization is not required to receive most care from these providers, a referral may be required in the following situations:

- The provider may have to get prior authorization for certain Services in accord with "Medical Group authorization procedure for certain referrals" in this "Getting a Referral" section
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition

Standing referrals

If a Plan Physician refers you to a specialist, the referral will be for a specific treatment plan. Your treatment plan may include a standing referral if ongoing care from the specialist is prescribed. For example, if you have a life-threatening, degenerative, or disabling condition, you can get a standing referral to a specialist if ongoing care from the specialist is required.

Medical Group authorization procedure for certain referrals

The following are examples of Services that require prior authorization by the Medical Group for the Services to be covered ("prior authorization" means that the Medical Group must approve the Services in advance):

- Durable medical equipment
- Ostomy and urological supplies
- Services not available from Plan Providers
- Transplants

Utilization Management ("UM") is a process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UM process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at **kp.org/UM** or call Member Services to request a printed copy.

Refer to "Post-Stabilization Care" under "Emergency Services" in this "How to Obtain Services" section for authorization requirements that apply to Post-Stabilization Care from Non–Plan Providers.

Additional information about prior authorization for durable medical equipment and ostomy and urological supplies

The prior authorization process for durable medical equipment and ostomy and urological supplies includes the use of formulary guidelines. These guidelines were developed by a multidisciplinary clinical and operational work group with review and input from Plan Physicians and medical professionals with clinical expertise. The formulary guidelines are periodically updated to keep pace with changes in medical technology and clinical practice.

If your Plan Physician prescribes one of these items, they will submit a written referral in accord with the UM process described in this "Medical Group authorization procedure for certain referrals" section. If the formulary guidelines do not specify that the prescribed item is appropriate for your medical condition, the referral will be submitted to the Medical Group's designee Plan Physician, who will make an authorization decision as described under "Medical Group's decision time frames" in this "Medical Group authorization procedure for certain referrals" section.

Additional information about utilization review determination criteria for mental health Services or substance use disorder treatment

Utilization review determination criteria and any education program materials for individuals making authorization decisions related to mental health Services or substance use disorder treatment are available at **kp.org** at no cost.

Medical Group's decision time frames

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

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your physician will be informed of the scope of the authorized Services. If the Medical Group does not authorize all of the Services, Health Plan will send you a written decision and explanation within two business days after the decision is made. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request.

If the Medical Group does not authorize all of the Services requested and you want to appeal the decision, you can file a grievance as described under "Grievances" in the "Dispute Resolution" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Completion of Services from Non–Plan Providers

New Member

If you are currently receiving Services from a Non–Plan Provider in one of the cases listed below under "Eligibility," and you were covered under another health plan when you began receiving the Services, but your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective, you may be eligible for limited coverage of that Non–Plan Provider's Services.

Terminated provider

If you are currently receiving covered Services in one of the cases listed below under "Eligibility" from a Plan Hospital or a Plan Physician (or certain other providers) when our contract with the provider ends (for reasons other than medical disciplinary cause or criminal activity), you may be eligible for limited coverage of that terminated provider's Services.

Eligibility

The cases that are subject to this completion of Services provision are:

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness,

injury, or other medical problem that requires prompt medical attention and has a limited duration. We may cover these Services until the acute condition ends

- Serious chronic conditions until the earlier of (1) 12 months from your effective date of coverage if you are a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non–Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
  - it persists without full cure
  - it worsens over an extended period of time
  - it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Mental health conditions in pregnant Members that occur, or can impact the Member, during pregnancy or during the postpartum period including, but not limited to, postpartum depression. We may cover completion of these Services for up to 12 months from the mental health diagnosis or from the end of pregnancy, whichever occurs later
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Children under age 3. We may cover completion of these Services until the earlier of (1) 12 months from the child's effective date of coverage if the child is a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the child's third birthday
- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of your effective date of coverage if you are a new Member or within 180 days of the termination date of the terminated provider

To qualify for this completion of Services coverage, all of the following requirements must be met:

- Your Health Plan coverage is in effect on the date you receive the Services
- For new Members, your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective
- You are receiving Services in one of the cases listed above from a Non–Plan Provider on your effective date of coverage if you are a new Member, or from the terminated Plan Provider on the provider's termination date
- For new Members, when you enrolled in Health Plan, you did not have the option to continue with your previous health plan or to choose another plan (including an out-of-network option) that would cover the Services of your current Non–Plan Provider
- The provider agrees to our standard contractual terms and conditions, such as conditions pertaining to payment and to providing Services inside your Service Area (the requirement that the provider agree to providing Services inside your Service Area doesn't apply if you were receiving covered Services from the provider outside your Service Area when the provider's contract terminated)
- The Services to be provided to you would be covered Services under this *EOC* if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from your effective date of coverage if you are a new Member or from the termination date of the Plan Provider

For completion of Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

More information

For more information about this provision, or to request the Services or a copy of our "Completion of Covered Services" policy, please call Member Services.

Travel and Lodging for Certain Services

The following are examples of when we will arrange or provide reimbursement for certain travel and lodging expenses in accord with our Travel and Lodging Program Description:

- If Medical Group refers you to a provider that is more than 50 miles from where you live for certain specialty Services such as bariatric surgery, complex thoracic surgery, transplant nephrectomy, or inpatient chemotherapy for leukemia and lymphoma
- If Medical Group refers you to a provider that is outside your Service Area for certain specialty Services such as a transplant or transgender surgery

- If you are outside of California and you need an abortion on an emergency or urgent basis, and the abortion can't be obtained in a timely manner due to a near total or total ban on Health Care Providers' ability to provide such Services

For the complete list of specialty Services for which we will arrange or provide reimbursement for travel and lodging expenses, the amount of reimbursement, limitations and exclusions, and how to request reimbursement, refer to the Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at **kp.org/specialty-care/travel-reimbursements** or by calling Member Services.

Second Opinions

If you want a second opinion, you can ask Member Services to help you arrange one with a Plan Physician who is an Appropriately Qualified Health Care Professional for your condition. If there isn't a Plan Physician who is an Appropriately Qualified Health Care Professional for your condition, Member Services will help you arrange a consultation with a Non–Plan Physician for a second opinion.

Here are some examples of when a second opinion may be provided or authorized:

- Your Plan Physician has recommended a procedure and you are unsure about whether the procedure is reasonable or necessary
- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions
- The clinical indications are not clear or are complex and confusing
- A diagnosis is in doubt due to conflicting test results
- The Plan Physician is unable to diagnose the condition
- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have concerns about the diagnosis or plan of care

An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial and of your right to file a grievance as described under "Grievances" in the "Dispute Resolution" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Contracts with Plan Providers

How Plan Providers are paid

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Physicians are paid to provide or arrange medical and hospital Services for Members, please visit our website at **kp.org** or call Member Services.

Financial liability

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may have to pay the full price of noncovered Services you obtain from Plan Providers or Non–Plan Providers.

When you are referred to a Plan Provider for covered Services, you pay the Cost Share required for Services from that provider as described in this *EOC*.

Termination of a Plan Provider's contract

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for the covered Services you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements. You may be eligible to receive Services from a terminated provider; refer to "Completion of Services from Non–Plan Providers" under "Getting a Referral" in this "How to Obtain Services" section.

Provider groups and hospitals

If you are assigned to a provider group or hospital whose contract with us terminates, or if you live within 15 miles of a hospital whose contract with us terminates, we will give you written notice at least 60 days before the termination (or as soon as reasonably possible).

Receiving Care Outside of Your Home Region

For information about your coverage when you are away from home, visit our website at **kp.org/travel**. You can also call the Away from Home Travel Line at

1-951-268-3900 24 hours a day, seven days a week (closed holidays).

Receiving care in another Kaiser Permanente Service Area

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

For covered Services you receive in another Kaiser Permanente Service Area, you pay the Cost Share required for Services provided by a Plan Provider inside your Service Area as described in this *EOC*.

Receiving care outside of any Kaiser Permanente Service Area

If you are traveling outside of any Kaiser Permanente Service Area, we cover Emergency Services and Care and Urgent Care as described in this "How to Obtain Services" section.

Your ID Card

Each Member's Kaiser Permanente ID card has a medical record number on it, which you will need when you call for advice, make an appointment, or go to a provider for covered care. When you get care, please bring your ID card and a photo ID. Your medical record number is used to identify your medical records and membership information. Your medical record number should never change. Please call Member Services if we ever inadvertently issue you more than one medical record number or if you need to replace your ID card.

Your ID card is for identification only. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-Member for any Services they receive. If you let someone else use your ID card, we may keep your ID card and terminate your membership as described under "Termination for Cause" in the "Termination of Membership" section.

Timely Access to Care

Standards for appointment availability

The California Department of Managed Health Care ("DMHC") developed the following standards for appointment availability. This information can help you know what to expect when you request an appointment.

- Urgent care appointment: within 48 hours
- Routine (non-urgent) primary care appointment (including adult/internal medicine, pediatrics, and family medicine): within 10 business days
- Routine (non-urgent) specialty care appointment with a physician: within 15 business days
- Routine (non-urgent) mental health care or substance use disorder treatment appointment with a practitioner other than a physician: within 10 business days
- Follow-up (non-urgent) mental health care or substance use disorder treatment appointment with a practitioner other than a physician, for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition: within 10 business days

If you prefer to wait for a later appointment that will better fit your schedule or to see the Plan Provider of your choice, we will respect your preference. In some cases, your wait may be longer than the time listed if a licensed health care professional decides that a later appointment won't have a negative effect on your health.

The standards for appointment availability do not apply to Preventive Services. Your Plan Provider may recommend a specific schedule for Preventive Services, depending on your needs. Except as specified above for mental health care and substance use disorder treatment, the standards also do not apply to periodic follow-up care for ongoing conditions or standing referrals to specialists.

Timely access to telephone assistance

DMHC developed the following standards for answering telephone questions:

- For telephone advice about whether you need to get care and where to get care: within 30 minutes, 24 hours a day, seven days a week
- For general questions: within 10 minutes during normal business hours

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. For more information

on the interpreter services we offer, please call Member Services.

Access to mental health Services and substance use disorder treatment

State law requires evidence of coverage documents to include the following notice:

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Health Plan fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at http://www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

Getting Assistance

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your personal Plan Physician or with other Plan Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Member Services

Member Services representatives can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain the following:

- Your Health Plan benefits
- How to make your first medical appointment
- What to do if you move
- How to replace your Kaiser Permanente ID card

You can reach Member Services in the following ways:

Call	**1-800-464-4000 (**English and more than 150 languages using interpreter services**)** **1-800-788-0616 (**Spanish**)** **1-800-757-7585 (**Chinese dialects**)** TTY users call **711** 24 hours a day, seven days a week (closed holidays)
Visit	Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
Write	Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
Website	**kp.org**

Cost Share estimates

For information about estimates, see “Getting an estimate of your Cost Share” under “Your Cost Share” in the “Benefits” section.

Plan Facilities

Plan Medical Offices and Plan Hospitals are listed in the Provider Directory for your Service Area. The directory describes the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services. This directory is available on our website at **kp.org/facilities**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call Member Services.

At most of our Plan Facilities, you can usually receive all of the covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you:

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services and Care are available from Plan Hospital emergency departments (for emergency department locations, refer to our Provider Directory or call Member Services)
- Same-day Urgent Care appointments are available at many locations (for Urgent Care locations, refer to our Provider Directory or call Member Services)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services office (for locations, refer to our Provider Directory or call Member Services)

Note: State law requires evidence of coverage documents to include the following notice:

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Kaiser Permanente Member Services, to ensure that you can obtain the health care services that you need.

Please be aware that if a Service is covered but not available at a particular Plan Facility, we will make it available to you at another facility.

Benefits

This section describes Covered Benefits under this *EOC*.

Services are covered under this *EOC* as specifically described in this *EOC*. Services that are not specifically described in this *EOC* are not covered, except as required by state or federal law. Services are subject to exclusions and limitations described in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. Except as otherwise described in this *EOC*, all of the following conditions must be satisfied:

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
  - Preventive Services
  - health care items and services for diagnosis, assessment, or treatment
  - health education covered under "Health Education" in this "Benefits" section
  - other health care items and services
- The Services are provided, prescribed, authorized, or directed by a Plan Physician, except for:
  - covered Services received outside of your Service Area, as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section
  - COVID-19 Services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Pharmacy Services," and "Preventive Services" below
  - drugs prescribed by dentists, as described under "Outpatient Pharmacy Services" below
  - emergency ambulance Services, as described under "Ambulance Services" below
  - Emergency Services and Care, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "How to Obtain Services" section
  - eyeglasses and contact lenses prescribed by Non–Plan Providers, as described under "Vision Services for Adult Members" and "Vision Services for Pediatric Members" below

- You receive the Services from Plan Providers inside your Service Area, except for:
  - ♦ authorized referrals, as described under "Getting a Referral" in the "How to Obtain Services" section
  - ♦ covered Services received outside of your Service Area, as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section
  - ♦ COVID-19 Services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Pharmacy Services," and "Preventive Services" below
  - ♦ emergency ambulance Services, as described under "Ambulance Services" below
  - ♦ Emergency Services and Care, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "How to Obtain Services" section
  - ♦ hospice care, as described under "Hospice Care" below
- The Medical Group has given prior authorization for the Services, if required, as described under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

Please also refer to:

- The "How to Obtain Services" section for information about how to obtain covered Emergency Services and Care, Post-Stabilization Care, and Out-of-Area Urgent Care
- Our Provider Directory for the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services

Your Cost Share

Your Cost Share is the amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance.

If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Similarly, if your coverage includes a Drug Deductible, and you receive Services that are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Refer to the "Cost Share Summary" section of this *EOC* for the amount you will pay for Services.

General rules, examples, and exceptions

Your Cost Share for covered Services will be the Cost Share in effect on the date you receive the Services, except as follows:

- If you are receiving covered hospital inpatient or Skilled Nursing Facility Services on the effective date of this *EOC*, you pay the Cost Share in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Share in effect on the date you receive the Services
- For items ordered in advance, you pay the Cost Share in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Share when the item is ordered. For Prescription Drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription

Cost Share for Services received by newborn children of a Member

During the 31 days of automatic coverage for newborn children described under "If you have a baby" under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, the parent or guardian of the newborn must pay the Cost Share indicated in the "Cost Share Summary" section of this *EOC* for any Services that the newborn receives, whether or not the newborn is enrolled. When the "Cost Share Summary" indicates the Services are subject to the Plan Deductible, the Cost Share for those Services will be Charges if the newborn has not met the Plan Deductible.

Payment toward your Cost Share (and when you may be billed)

In most cases, your provider will ask you to make a payment toward your Cost Share at the time you receive Services. If you receive more than one type of Services (such as a routine physical maintenance exam and laboratory tests), you may be required to pay separate Cost Share for each of those Services. Keep in mind that your payment toward your Cost Share may cover only a portion of your total Cost Share for the Services you receive, and you will be billed for any additional amounts that are due. The following are examples of when you may be asked to pay (or you may be billed for) Cost Share amounts in addition to the amount you pay at check-in:

- You receive non-preventive Services during a preventive visit. For example, you go in for a routine physical maintenance exam, and at check-in you pay your Cost Share for the preventive exam (your Cost Share may be "no charge"). However, during your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional non-preventive diagnostic Services
- You receive diagnostic Services during a treatment visit. For example, you go in for treatment of an existing health condition, and at check-in you pay your Cost Share for a treatment visit. However, during the visit your provider finds a new problem with your health and performs or orders diagnostic Services (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional diagnostic Services
- You receive treatment Services during a diagnostic visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider confirms a problem with your health and performs treatment Services (such as an outpatient procedure). You may be asked to pay (or you will be billed for) your Cost Share for these additional treatment Services
- You receive Services from a second provider during your visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay (or you will be billed for) your Cost Share for the consultation with the specialist

In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for your Cost Share (for example, some Laboratory Departments are not able to collect Cost Share, or your Plan Provider is not able to collect Cost Share, if any, for Telehealth Visits you receive at home).

When we send you a bill, it will list Charges for the Services you received, payments and credits applied to your account, and any amounts you still owe. Your current bill may not always reflect your most recent Charges and payments. Any Charges and payments that are not on the current bill will appear on a future bill. Sometimes, you may see a payment but not the related Charges for Services. That could be because your payment was recorded before the Charges for the Services were processed. If so, the Charges will appear on a future bill. Also, you may receive more than one bill for a single outpatient visit or inpatient stay. For example, you may receive a bill for physician services and a separate bill for hospital services. If you don't see all the Charges for Services on one bill, they will appear on a future bill. If we determine that you overpaid and are due a refund, then we will send a refund to you within four weeks after we make that determination. If you have questions about a bill, please call the phone number on the bill.

In some cases, a Non–Plan Provider may be involved in the provision of covered Services at a Plan Facility or a contracted facility where we have authorized you to receive care. You are not responsible for any amounts beyond your Cost Share for the covered Services you receive at Plan Facilities or at contracted facilities where we have authorized you to receive care. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Please refer to "Emergency Services and Urgent Care" in this "Benefits" section for more information about when you may be billed for Emergency Services and Care, Post-Stabilization Care, and Out-of-Area Urgent Care.

Reimbursement for COVID-19 Services from Non-Plan Providers

If you receive covered COVID-19 Services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Pharmacy Services," and "Preventive Services" in the "Benefits" section, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see "Initial Claims" in the "the "Post-Service Claims and Appeals" section.

Primary Care Visits, Non-Physician Specialist Visits, and Physician Specialist Visits

The Cost Share for a Primary Care Visit applies to evaluations and treatment provided by generalists in internal medicine, pediatrics, or family practice, and by specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Some physician specialists provide primary care in addition to specialty care but are not designated as Primary Care Physicians. If you receive Services from one of these specialists, the Cost Share for a Physician Specialist Visit will apply to all consultations, evaluations, and treatment provided by the specialist except for routine preventive counseling and exams listed under "Preventive Services" in this "Benefits" section. For example, if your personal

Plan Physician is a specialist in internal medicine or obstetrics/gynecology who is not a Primary Care Physician, you will pay the Cost Share for a Physician Specialist Visit for all consultations, evaluations, and treatment by the specialist except routine preventive counseling and exams listed under "Preventive Services" in this "Benefits" section. The Non-Physician Specialist Visit Cost Share applies to consultations, evaluations, and treatment provided by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

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

Noncovered Services
If you receive Services that are not covered under this *EOC*, you may have to pay the full price of those Services. Payments you make for noncovered Services do not apply to any deductible or out-of-pocket maximum.

When a Service is not covered, all Services related to the noncovered Service are also not covered, except for Services we would otherwise cover to treat complications of the noncovered Service, or as required by law. For example, if you have a noncovered cosmetic surgery, we would not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, we would cover any Services that we would otherwise cover to treat that complication.

Benefit limits
Some benefits may include a limit on the number of visits, days, treatment cycles, or dollar amount that will be covered under your plan during a specified time period. If a benefit includes a limit, this will be indicated in the "Cost Share Summary" section of this *EOC*. The time period associated with a benefit limit may not be the same as the term of this *EOC*. We will count all Services you receive during the benefit limit period toward the benefit limit, including Services you received under a prior Health Plan *EOC* (as long as you have continuous coverage with Health Plan). Note: We will not count Services you received under a prior Health Plan *EOC* when you first enroll in individual plan coverage or a new employer group's plan, when you move from group to individual plan coverage (or vice versa), or when you received Services under a Kaiser Permanente Senior Advantage evidence of coverage. If you are enrolled in the Kaiser Permanente POS Plan, refer to your KPIC *Certificate of Insurance* and *Schedule of Coverage* for benefit limits that apply to your separate indemnity coverage provided by the Kaiser Permanente Insurance Company ("KPIC").

Getting an estimate of your Cost Share
If you have questions about the Cost Share for specific Services that you expect to receive or that your provider orders during a visit or procedure, please visit our website at **kp.org** to use our cost estimate tool or call Member Services.

- If you have a Plan Deductible and would like an estimate for Services that are subject to the Plan Deductible, please call **1-800-390-3507** (TTY users call **711**) Monday through Friday 6 a.m. to 5 p.m. Refer to the "Cost Share Summary" section of this *EOC* to find out if you have a Plan Deductible
- For all other Cost Share estimates, please call **1-800-464-4000** (TTY users call **711**) 24 hours a day, seven days a week (closed holidays)

Cost Share estimates are based on your benefits and the Services you expect to receive. They are a prediction of cost and not a guarantee of the final cost of Services. Your final cost may be higher or lower than the estimate since not everything about your care can be known in advance.

Drug Deductible
This *EOC* does not include a Drug Deductible.

Plan Deductible
This *EOC* does not include a Plan Deductible.

Copayments and Coinsurance
The Copayment or Coinsurance you must pay for each covered Service, after you meet any applicable deductible, is described in this *EOC*.

Note: If Charges for Services are less than the Copayment described in this *EOC*, you will pay the lesser amount, subject to any applicable deductible or out-of-pocket maximum.

Plan Out-of-Pocket Maximum
There is a limit to the total amount of Cost Share you must pay under this *EOC* in the Accumulation Period for covered Services that you receive in the same Accumulation Period. The Services that apply to the Plan Out-of-Pocket Maximum are described under the "Payments that count toward the Plan Out-of-Pocket Maximum" section below. Refer to the "Cost Share Summary" section of this *EOC* for your applicable Plan Out-of-Pocket Maximum amounts.

If you are a Member in a Family of two or more Members, you reach the Plan Out-of-Pocket Maximum either when you reach the maximum for any one Member, or when your Family reaches the Family maximum. For example, suppose you have reached the Plan Out-of-Pocket Maximum for any one Member. For Services subject to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share during the remainder of the Accumulation Period, but every other Member in your Family must continue to pay Cost Share during the remainder of the Accumulation Period until either they reach the maximum for any one Member or your Family reaches the Family maximum.

Payments that count toward the Plan Out-of-Pocket Maximum

Any payments you make toward the Plan Deductible or Drug Deductible, if applicable, apply toward the maximum.

Most Copayments and Coinsurance you pay for covered Services apply to the maximum, however some may not. To find out whether a Copayment or Coinsurance for a covered Service will apply to the maximum refer to the "Cost Share Summary" section of this *EOC*.

Accrual toward deductibles and out-of-pocket maximums

To see how close you are to reaching your deductibles, if any, and out-of-pocket maximums, use our online Out-of-Pocket Summary tool at **kp.org** or call Member Services. We will provide you with accrual balance information for every month that you receive Services until you reach your individual out-of-pocket maximums or your Family reaches the Family out-of-pocket maximums.

We will provide accrual balance information by mail unless you have opted to receive notices electronically. You can change your document delivery preferences at any time at **kp.org** or by calling Member Services.

Administered Drugs and Products

Administered drugs and products are medications and products that require administration or observation by medical personnel, such as:

- Whole blood, red blood cells, plasma, and platelets
- Allergy antigens (including administration)
- Cancer chemotherapy drugs and adjuncts
- Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products ("biologics") derived from tissue, cells, or blood
- Other administered drugs and products

We cover these items when prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility or during home visits.

For the following Services, refer to these sections

- Administered contraceptives (refer to "Reproductive Health Services")
- All other administered drugs that are Preventive Services, including immunizations (refer to "Preventive Services")

Ambulance Services

Emergency

We cover Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

- You reasonably believed that the medical condition was an Emergency Medical Condition or Psychiatric Emergency Medical Condition which required ambulance Services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition or Psychiatric Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

If you receive emergency ambulance Services that are not ordered by a Plan Provider, you are not responsible for any amounts beyond your Cost Share for covered emergency ambulance Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Nonemergency

Inside your Service Area, we cover nonemergency ambulance and psychiatric transport van Services if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to or from covered Services.

Covered nonemergency ambulance and psychiatric transport van Services do not include the following services:

- Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van), even if it is the only way to travel to a Plan Provider

Bariatric Surgery

We cover hospital inpatient Services related to bariatric surgical procedures (including room and board, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

- You complete the Medical Group–approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success
- A Plan Physician who is a specialist in bariatric care determines that the surgery is Medically Necessary

For covered Services related to bariatric surgical procedures that you receive, you will pay the Cost Share you would pay if the Services were not related to a bariatric surgical procedure. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services.

For the following Services, refer to these sections

- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Prescription Drugs (refer to "Outpatient Pharmacy Services")

Dental and Orthodontic Services

We do not cover most dental and orthodontic services under this *EOC*, such as dental cleanings, dental X-rays, appliances, and implants, but we do cover some dental and orthodontic Services as described in this "Dental and Orthodontic Services" section.

For covered dental and orthodontic procedures that you may receive, you will pay the Cost Share you would pay if the Services were not related to dental and orthodontic Services. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services.

Dental Services for radiation treatment

We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist for those Services (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental Services for transplants

We cover dental services that are Medically Necessary to free the mouth from infection in order to prepare for a transplant covered under "Transplant Services" in this "Benefits" section, if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist for those Services (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental anesthesia

For dental procedures at a Plan Facility, we provide general anesthesia and the facility's Services associated with the anesthesia if all of the following are true:

- You are under age 7, or you are developmentally disabled, or your health is compromised
- Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
- The dental procedure would not ordinarily require general anesthesia

We do not cover any other Services related to the dental procedure, such as the dentist's Services.

Dental and orthodontic Services for cleft palate

We cover dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic Services, if they meet all of the following requirements:

- The Services are an integral part of a reconstructive surgery for cleft palate that we are covering under "Reconstructive Surgery" in this "Benefits" section ("cleft palate" includes cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate)
- A Plan Provider provides the Services or the Medical Group authorizes a referral to a Non–Plan Provider who is a dentist or orthodontist (as described in "Medical Group authorization procedure for certain

referrals" under "Getting a Referral" in the "How to Obtain Services" section)

For the following Services, refer to these sections

- Accidental injury to teeth (refer to "Injury to Teeth")
- Office visits not described in the "Dental and Orthodontic Services" section (refer to "Office Visits")
- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient administered drugs (refer to "Administered Drugs and Products"), except that we cover outpatient administered drugs under "Dental anesthesia" in this "Dental and Orthodontic Services" section
- Prescription Drugs (refer to "Outpatient Pharmacy Services")
- Telehealth Visits (refer to "Telehealth Visits")

Dialysis Care

We cover acute and chronic dialysis Services if all of the following requirements are met:

- The Services are provided inside your Service Area
- You satisfy all medical criteria developed by the Medical Group and by the facility providing the dialysis
- A Plan Physician provides a written referral for care at the facility

After you receive appropriate training at a dialysis facility we designate, we also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside your Service Area. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

Covered dialysis care does not include the following services:

- Comfort, convenience, or luxury equipment, supplies and features
- Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

For the following Services, refer to these sections

- Durable medical equipment for home use (refer to "Durable Medical Equipment ("DME") for Home Use")
- Hospital inpatient Services (refer to "Hospital Inpatient Services")
- Office visits not described in the "Dialysis Care" section (refer to "Office Visits")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Prescription Drugs (refer to "Outpatient Pharmacy Services")
- Telehealth Visits (refer to "Telehealth Visits")

Durable Medical Equipment ("DME") for Home Use

DME coverage rules

DME for home use is an item that meets the following criteria:

- The item is intended for repeated use
- The item is primarily and customarily used to serve a medical purpose
- The item is generally useful only to an individual with an illness or injury
- The item is appropriate for use in the home

For a DME item to be covered, all of the following requirements must be met:

- Your *EOC* includes coverage for the requested DME item
- A Plan Physician has prescribed the DME item for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside your Service Area

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay

us the fair market price of the equipment when we are no longer covering it.

Covered DME for home use does not include the following services:

- Comfort, convenience, or luxury equipment or features except for retail-grade milk pumps as described under "Lactation supplies" in this "Durable Medical Equipment ("DME") for Home Use" section
- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including devices intended to provide additional support for recreational or sports activities)
- Hygiene equipment
- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car
- Devices for testing blood or other body substances (except diabetes glucose monitors and their supplies)
- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to loss, theft, or misuse

Base DME Items

We cover Base DME Items (including repair or replacement of covered equipment) if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met. "Base DME Items" means the following items:

- Bone stimulator
- Canes (standard curved handle or quad) and replacement supplies
- Cervical traction (over door)
- Crutches (standard or forearm) and replacement supplies
- Dry pressure pad for a mattress
- Glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Infusion pumps (such as insulin pumps) and supplies to operate the pump
- IV pole
- Nebulizer and supplies
- Peak flow meters
- Phototherapy blankets for treatment of jaundice in newborns

Supplemental DME items

Subject to the benefit limit described under "DME benefit limit" in this "Durable Medical Equipment ("DME") for Home Use" section, we cover DME that is not described under "Base DME Items" or "Lactation supplies," including repair and replacement of covered equipment, if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met.

Lactation supplies

We cover one retail-grade milk pump (also known as a breast pump) per pregnancy and associated supplies, as listed on our website at **kp.org/prevention**. We will decide whether to rent or purchase the item and we choose the vendor. We cover this pump for convenience purposes. The pump is not subject to prior authorization requirements.

If you or your baby has a medical condition that requires the use of a milk pump, we cover a hospital-grade milk pump and the necessary supplies to operate it, in accord with the coverage rules described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section.

DME benefit limit

For DME covered under the "Supplemental DME items" section (including repair and replacement of covered equipment), there is a benefit limit per Member per Accumulation Period. Refer to the "Cost Share Summary" section of this *EOC* for your benefit limit amount. We will calculate accumulation toward the benefit limit by adding up the Charges for the durable medical equipment you received in the Accumulation Period that are subject to the limit (including any of these items we covered under any other Health Plan evidence of coverage offered by your Group, whether or not the other evidence of coverage had a benefit limit), and subtracting any Cost Share you paid for those items. If you reach the benefit limit, we will not cover any more durable medical equipment in that Accumulation Period if they are subject to the benefit limit.

The following items are not subject to this benefit limit:

- Items listed under "Base DME Items" as described in this "Durable Medical Equipment ("DME") for Home Use" section
- Milk pumps and supplies as described in "Lactation Supplies" in this "Durable Medical Equipment ("DME") for Home Use" section

Outside your Service Area

We do not cover most DME for home use outside your Service Area. However, if you live outside your Service Area, we cover the following DME (subject to the Cost Share and all other coverage requirements that apply to DME for home use inside your Service Area) when the item is dispensed at a Plan Facility:

- Canes (standard curved handle)
- Crutches (standard)
- Glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices) from a Plan Pharmacy
- Insulin pumps and supplies to operate the pump, after completion of training and education on the use of the pump
- Nebulizers and their supplies for the treatment of pediatric asthma
- Peak flow meters from a Plan Pharmacy

For the following Services, refer to these sections

- Diabetes urine testing supplies and insulin-administration devices other than insulin pumps (refer to "Outpatient Pharmacy Services")
- Dialysis equipment and supplies required for home hemodialysis and home peritoneal dialysis (refer to "Dialysis Care")
- Durable medical equipment related to an Emergency Medical Condition or Urgent Care episode (refer to "Post-Stabilization Care" and "Out-of-Area Urgent Care")
- Durable medical equipment related to the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Insulin and any other drugs administered with an infusion pump (refer to "Outpatient Pharmacy Services")

Emergency Services and Urgent Care

We cover the following Services:

- Emergency department visits
- Urgent Care consultations, evaluations, and treatment

Your Cost Share

Your Cost Share for covered Emergency Services and Care and Post-Stabilization Care is described in the "Cost Share Summary" section of this *EOC*. Your Cost Share is the same whether you receive the Services from a Plan Provider or a Non–Plan Provider. For example:

- If you receive Emergency Services and Care in the emergency department of a Non–Plan Hospital, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Urgent Care"
- If we gave prior authorization for inpatient Post-Stabilization Care in a Non–Plan Hospital, you pay the Cost Share for hospital inpatient Services as described in the "Cost Share Summary" under "Hospital inpatient Services"
- If we gave prior authorization for durable medical equipment after discharge from a Non–Plan Hospital, you pay the Cost Share for durable medical equipment as described in the "Cost Share Summary" under "Durable Medical Equipment ("DME") for home use"
- If you receive COVID-19 laboratory testing or immunizations in the emergency department, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Urgent Care"
- If you obtain a prescription in the emergency department related to your Emergency Medical Condition or Psychiatric Emergency Medical Condition, you pay the Cost Share for "Most items" in the "Cost Share Summary" under "Outpatient pharmacy Services" in addition to the Cost Share for the emergency department visit

Your Cost Share for covered Urgent Care is the Cost Share required for Services provided by Plan Providers as described in the "Cost Share Summary" section of this *EOC*. For example:

- If you receive an Urgent Care evaluation as part of covered Out-of-Area Urgent Care from a Non–Plan Provider, you pay the Cost Share for Urgent Care consultations, evaluations, and treatment as described in the "Cost Share Summary" under "Emergency Services and Urgent Care"
- If the Out-of-Area Urgent Care you receive includes an X-ray, you pay the Cost Share for an X-ray as described in the "Cost Share Summary" under "Outpatient imaging, laboratory, and other diagnostic and treatment Services," in addition to the Cost Share for the Urgent Care evaluation
- If the Out-of-Area Urgent Care you receive includes a COVID-19 test, you may have to pay the Cost Share for a COVID-19 test as described in the "Cost Share Summary" under "Outpatient imaging, laboratory, and other diagnostic and treatment Services," in

addition to the Cost Share for the Urgent Care evaluation

- If you obtain a prescription as part of an Out-of-Area Urgent Care visit related to the condition for which you obtained Urgent Care, you pay the Cost Share for "Most items" in the "Cost Share Summary" under "Outpatient pharmacy Services" in addition to the Cost Share for the Urgent Care evaluation
- If we gave prior authorization for durable medical equipment provided as part of Out-of-Area Urgent Care, you pay the Cost Share for durable medical equipment as described in the "Cost Share Summary" under "Durable Medical Equipment ("DME") for home use"

Note: If you receive Urgent Care in an emergency department, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Urgent Care."

If a Non-Plan Provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. Also, you may be required to pay and file a claim for any Services prescribed by a Non–Plan Provider as part of covered Emergency Services and Care, Post-Stabilization Care, or Out-of-Area Urgent Care even if you receive the Services from a Plan Provider, such as a Plan Pharmacy. For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")

Fertility Services

"Fertility Services" means treatments and procedures to help you become pregnant.

We cover the following Fertility Services:

- Diagnosis and treatment of Infertility
- Artificial insemination
- Up to three oocyte retrievals per lifetime
- Cryopreservation and one-time storage up to 6 months of embryos related to a covered treatment cycle
- Transfer of fresh and cryopreserved embryo(s)

If you reach the lifetime maximum for oocyte retrievals, we will not cover any Services related to additional oocyte retrievals including Prescription Drugs.

Before starting or continuing a course of fertility Services, you may be required to pay initial and subsequent deposits toward your Cost Share for some or all of the entire course of Services, along with any past-due fertility-related Cost Share. Any unused portion of your deposit will be returned to you. When a deposit is not required, you must pay the Cost Share for the procedure, along with any past-due fertility-related Cost Share, before you can schedule a fertility procedure.

Covered Fertility Services do not include the following services:

- Services related to the procurement, cryopreservation, and storage of semen and eggs, except if the retrieval is part of your covered fertility Services
- Services related to the procurement, cryopreservation, and storage of embryos, except for storage of embryos that is part of your covered fertility Services

For the following Services, refer to these sections

- Diagnostic Services provided by Plan Providers who are not physicians, such as EKGs and EEGs (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Prescription Drugs (refer to "Outpatient Pharmacy Services")

Fertility Preservation Services for Iatrogenic Infertility

Standard Fertility Preservation Services are covered in the following situations:

- A Plan Provider has recommended that you undergo covered treatment or receive covered Services within the next 12 months that may cause iatrogenic infertility.
- You received covered treatment or covered Services that may cause iatrogenic infertility, you were unable to undergo or complete fertility preservation due to your medical condition, and you face an ongoing risk for infertility caused by those treatments

Standard Fertility Preservation Services do not include diagnosis or treatment of Infertility.

We cover the following Standard Fertility Preservation Services:

- Retrieval of gametes:
  - Up to two cycles for oocyte retrieval for Members with ovaries per lifetime
  - Up to two attempts to collect sperm for Members with testicles per lifetime
- Up to two attempts of embryo creation per lifetime, except that we do not cover any costs associated with the retrieval of gametes from anyone other than the Member undergoing the medical treatment that may cause iatrogenic infertility
- Up to two attempts to retrieve gonadal tissue per lifetime
- Gonadal shielding or transposition during a procedure or treatment if not already included in the usual coverage for that procedure or treatment
- Any other Standard Fertility Preservation Services consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine
- Cryopreservation and storage of sperm, oocytes, gonadal tissue, and embryos from a vendor that we select for the following time period based on your age on the date that the material is first cryopreserved:
  - for a Member who is under the age of 18: until the Member reaches age 26
  - for a Member who is 18 years or older but not yet 26 years old: until the Member reaches age 26 or for three years, whichever period is longer
  - for a Member who is 26 years or older: three years

Your coverage for cryopreservation storage from us ends when your membership terminates. If you change health plans during the cryopreservation storage period described above, you must notify your new health plan that you want them to cover storage starting from the effective date of your coverage in that plan. We will work with the new plan to coordinate transportation of stored material, if required. If you are still a Member when your storage period expires, you will receive a notice 90 days before the storage period expires that explains options for continued storage and potential out-of-pocket costs.

For covered Standard Fertility Preservation Services that you receive, you will pay the Cost Share you would pay if the Services were not related to fertility preservation. For example, see “Outpatient surgery and outpatient procedures” in the “Cost Share Summary” section of this *EOC* for the Cost Share that applies for outpatient procedures.

You have the right to receive standard fertility preservation services for iatrogenic infertility when you meet the requirements in Section 1300.74.551 of Title 28 of the California Code of Regulations. "Iatrogenic infertility" means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment. If your health Plan fails to arrange those services for you with an appropriate provider who is in your health plan's network, your health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you will pay no more than in-network costsharing for the same services.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days for primary care and 15 business days for specialist care from when you requested the services from your health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if your health plan does not require prior authorization for the appointment) or within 96 hours (if your health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. If you are enrolled in preferred provider organization (PPO) coverage, and your health plan can arrange care for you within the timeframes and within geographic standards, your voluntary use of out-of-network benefits

may subject you to incur out-of-network charges.

If you have questions about how to obtain standard fertility preservation services for iatrogenic infertility or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on your-health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.DMHC.ca.gov to request assistance in obtaining standard fertility preservation services for iatrogenic infertility.

For the following Services, refer to these sections

- Treatments and procedures to help you become pregnant (refer to "Fertility Services")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Prescription Drugs (refer to "Outpatient Pharmacy Services")

Health Education

We cover a variety of health education counseling, programs, and materials that your personal Plan Physician or other Plan Providers provide during a visit covered under another part of this *EOC*.

We also cover a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for tobacco cessation, stress management, and chronic conditions (such as diabetes and asthma). Kaiser Permanente also offers health education counseling, programs, and materials that are not covered, and you may be required to pay a fee.

For more information about our health education counseling, programs, and materials, please contact a Health Education Department or Member Services or go to our website at **kp.org**.

Hearing Services

We cover the following:

- Hearing exams with an audiologist to determine the need for hearing correction
- Physician Specialist Visits to diagnose and treat hearing problems

Hearing aids

We provide an Allowance for each ear toward the purchase price of a hearing aid (including fitting, counseling, adjustment, cleaning, and inspection) when prescribed by a Plan Physician or by a Plan Provider who is an audiologist. We will cover hearing aids for both ears only if both aids are required to provide significant improvement that is not obtainable with only one hearing aid. We will not provide the Allowance if we have provided an Allowance toward (or otherwise covered) a hearing aid within the previous 36 months. Also, the Allowance can only be used at the initial point of sale. If you do not use all of your Allowance at the initial point of sale, you cannot use it later. Refer to "Hearing Services" in the "Cost Share Summary" section of this *EOC* for your Allowance amount.

We select the provider or vendor that will furnish the covered hearing aids. Coverage is limited to the types and models of hearing aids furnished by the provider or vendor.

Covered hearing Services do not include the following services:

- Internally implanted hearing aids
- Replacement parts and batteries, repair of hearing aids, and replacement of lost or broken hearing aids (the manufacturer warranty may cover some of these)

For the following Services, refer to these sections

- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")
- Routine hearing screenings when performed as part of a routine physical maintenance exam (refer to "Preventive Services")
- Services related to the ear or hearing other than those described in this section, such as outpatient care to treat an ear infection or Prescription Drugs (refer to the applicable heading in this "Benefits" section)

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists.

We cover home health care only if all of the following are true:

- You are substantially confined to your home (or a friend's or relative's home)
- Your condition requires the Services of a nurse, physical therapist, occupational therapist, or speech therapist (home health aide Services are not covered unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide)
- A Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home
- The Services are provided inside your Service Area

We cover only part-time or intermittent home health care, as follows:

- Up to two hours per visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to four hours per visit for visits by a home health aide
- Up to three visits per day (counting all home health visits)
- Up to 100 visits per Accumulation Period (counting all home health visits)

Note: If a visit by a nurse, medical social worker, or physical, occupational, or speech therapist lasts longer than two hours, then each additional increment of two hours counts as a separate visit. If a visit by a home health aide lasts longer than four hours, then each additional increment of four hours counts as a separate visit. For example, if a nurse comes to your home for three hours and then leaves, that counts as two visits. Also, each person providing Services counts toward these visit limits. For example, if a home health aide and a nurse are both at your home during the same two hours, that counts as two visits.

Covered home health care does not include the following services:

- Care of a type that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. This care is excluded even if we would cover the care if it were provided by a qualified medical professional in a hospital or a Skilled Nursing Facility
- Care in the home if the home is not a safe and effective treatment setting

For the following Services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder (refer to "Mental Health Services")
- Dialysis care (refer to "Dialysis Care")
- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Outpatient physical, occupational, and speech therapy visits (refer to "Rehabilitative and Habilitative Services")
- Prescription Drugs (refer to "Outpatient Pharmacy Services")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Hospice Care

Hospice care is a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts of a Member experiencing the last phases of life due to a terminal illness. It also provides support to the primary caregiver and the Member's family. A Member who chooses hospice care is choosing to receive palliative care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice care benefits at any time.

We cover the hospice Services listed below only if all of the following requirements are met:

- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside your Service Area or inside California but within 15 miles or 30 minutes from your Service Area (including a friend's or relative's home even if you live there temporarily)
- The Services are provided by a licensed hospice agency that is a Plan Provider
- A Plan Physician determines that the Services are necessary for the palliation and management of your terminal illness and related conditions

If all of the above requirements are met, we cover the following hospice Services, if necessary for your hospice care:

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, and speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from a Plan Pharmacy. Certain drugs are limited to a maximum 30-day supply in any 30-day period (your Plan Pharmacy can tell you if a drug you take is one of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient Services limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling

We also cover the following hospice Services only during periods of crisis when they are Medically Necessary to achieve palliation or management of acute medical symptoms:

- Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
- Short-term inpatient Services required at a level that cannot be provided at home

Hospital Inpatient Services

We cover the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals inside your Service Area:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Plan Physicians, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, refer to "Outpatient Pharmacy Services" in this "Benefits" section)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and other diagnostic and treatment Services, including MRI, CT, and PET scans
- Whole blood, red blood cells, plasma, platelets, and their administration
- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge (for visits after you are released from the hospital, refer to "Office Visits" in this "Benefits" section)
- Behavioral Health Treatment for Autism Spectrum Disorder
- Respiratory therapy
- Physical, occupational, and speech therapy (including treatment in our organized, multidisciplinary rehabilitation program)
- Medical social services and discharge planning

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")
- Bariatric surgical procedures (refer to "Bariatric Surgery")
- Dental and orthodontic procedures (refer to "Dental and Orthodontic Services")
- Dialysis care (refer to "Dialysis Care")
- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Fertility Services (refer to "Fertility Services")
- Hospice care (refer to "Hospice Care")
- Mental health Services (refer to "Mental Health Services")

- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Reconstructive surgery Services (refer to "Reconstructive Surgery")
- Services in connection with a clinical trial (refer to "Services in Connection with a Clinical Trial")
- Skilled inpatient Services in a Plan Skilled Nursing Facility (refer to "Skilled Nursing Facility Care")
- Substance use disorder treatment Services (refer to "Substance Use Disorder Treatment")
- Transplant Services (refer to "Transplant Services")

Injury to Teeth

Services for accidental injury to teeth are not covered under this *EOC*.

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when the Services are for the prevention, diagnosis, or treatment of Mental Health Conditions. A "Mental Health Condition" is a mental health condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders.*

Outpatient mental health Services

We cover the following Services when provided by Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license:

- Individual and group mental health evaluation and treatment, including treatment of first episode psychosis
- Psychological testing when necessary to evaluate a Mental Health Condition
- Outpatient Services for the purpose of monitoring drug therapy
- Behavioral Health Treatment for Autism Spectrum Disorder
- Electroconvulsive therapy
- Transcranial magnetic stimulation

Intensive psychiatric treatment programs

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

- Partial hospitalization
- Multidisciplinary treatment in an intensive outpatient or day-treatment program
- Psychiatric observation for an acute psychiatric crisis

Residential treatment

Inside your Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized mental health treatment, the Services are generally and customarily provided by a mental health residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group mental health evaluation and treatment
- Medical services
- Medication monitoring
- Room and board
- Social services
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Pharmacy Services" in this "Benefits" section)
- Discharge planning

Gender-affirming Services

For covered Services you receive for treatment of gender dysphoria, as described in other parts of the "Benefits" section, you will pay the Cost Share you would pay if the Services were not related to gender dysphoria. For example:

- See "Administered Drugs" for administered drugs
- See "Office Visits" for consultations for gender dysphoria treatment, such as hormone therapy, and hair removal procedures
- See "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services" for laboratory and imaging Services
- See "Outpatient Pharmacy Services" for self-administered Prescription Drugs
- See "Reconstructive Surgery" for surgical Services

- See “Rehabilitative and Habilitative Services” for speech (voice) therapy

Inpatient psychiatric hospitalization

We cover inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and Services of Plan Physicians and other Plan Providers who are licensed health care professionals acting within the scope of their license.

Services from Non-Plan Providers

If we are not able to offer an appointment with a Plan Provider within required geographic and timely access standards, we will offer to refer you to a Non-Plan Provider (as described in “Medical Group authorization procedure for certain referrals” under “Getting a Referral” in the “How to Obtain Services” section).

Additionally, we cover Services provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services (collectively, “988 Services”) for medically necessary treatment of a mental health or substance use disorder without prior authorization until the condition is stabilized, as required by state law. After the mental health or substance use disorder condition has been stabilized, post-stabilization care from Non-Plan Providers is subject to prior authorization as described under “Post-Stabilization Care” in the “Emergency Services” section.

For these referral Services and 988 Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

For the following Services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder provided during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to “Hospital Inpatient Services” and “Skilled Nursing Facility Care”)
- Drugs administered by a mental health provider to treat a mental health condition (refer to “Administered Drugs and Products”)
- Durable medical equipment (refer to “Durable Medical Equipment (‘DME’) for Home Use”)
- Outpatient laboratory and sleep studies (refer to “Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services”)
- Outpatient physical, occupational, and speech therapy visits (refer to “Rehabilitative and Habilitative Services”)
- Prescription Drugs (refer to “Outpatient Pharmacy Services”)
- Telehealth Visits (refer to “Telehealth Visits”)

Office Visits

We cover the following:

- Primary Care Visits and Non-Physician Specialist Visits
- Physician Specialist Visits
- Group appointments
- Acupuncture Services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain)
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside your Service Area when care can best be provided in your home as determined by a Plan Physician

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to “Reproductive Health Services”)
- Outpatient physical, occupational, and speech therapy visits (refer to “Rehabilitative and Habilitative Services”)

Ostomy and Urological Supplies

We cover ostomy and urological supplies if the following requirements are met:

- A Plan Physician has prescribed ostomy and urological supplies for your medical condition
- The item has been approved for you through the Plan’s prior authorization process, as described in “Medical Group authorization procedure for certain referrals” under “Getting a Referral” in the “How to Obtain Services” section
- The Services are provided inside your Service Area

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor.

Covered ostomy and urological supplies do not include the following services:

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services

We cover the following Services only when part of care covered under other headings in this "Benefits" section. The Services must be prescribed by a Plan Provider.

- Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans
- Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds
- Nuclear medicine
- Routine retinal photography screenings
- Laboratory tests, including tests to monitor the effectiveness of dialysis and tests for specific genetic disorders for which genetic counseling is available
- Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs, EEGs, and sleep studies)
- Radiation therapy
- Ultraviolet light treatments, including ultraviolet light therapy equipment for home use, if (1) the equipment has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section and (2) the equipment is provided inside your Service Area. (Coverage for ultraviolet light therapy equipment is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.)

We cover laboratory tests to diagnose or screen for COVID-19 from Plan Providers or Non-Plan Providers, including a provider visit for purposes of receiving the laboratory test.

We cover up to a total of eight FDA-authorized over-the-counter COVID-19 tests per calendar month from Plan Providers or Non-Plan Providers. Over-the-counter tests are self-administered tests that deliver results at home and are available without a prescription. For purposes of this section, "Plan Provider" means a Plan Pharmacy, mail order delivery through our website at **kp.org**, or a participating retail pharmacy. For purposes of this section, a "Non-Plan Provider" means a pharmacy or online retailer that isn't a Plan Provider. To find out more about coverage and limitations, including the current list of Plan Providers, visit our website or call Member Services.

Covered outpatient imaging, laboratory, and other diagnostic and treatment Services do not include the following services:

- Ultraviolet light therapy comfort, convenience, or luxury equipment or features
- Repair or replacement of ultraviolet light therapy equipment due to loss, theft, or misuse

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")
- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Fertility Services (refer to "Fertility Services")
- Outpatient imaging and laboratory Services that are Preventive Services, such as routine mammograms, bone density scans, and laboratory screening tests (refer to "Preventive Services")
- Outpatient procedures that include imaging and diagnostic Services (refer to "Outpatient Surgery and Outpatient Procedures")

Outpatient Pharmacy Services

We cover Prescription Drugs specified in this "Outpatient Pharmacy Services" section, in accord with our drug formulary guidelines, subject to any applicable exclusions or limitations under this *EOC*. We cover items described in this section when prescribed as follows:

- Items prescribed by Plan Providers, within the scope of their licensure and practice
- Items prescribed by the following Non–Plan Providers:
  - Dentists if the drug is for dental care
  - Non–Plan Physicians if the Medical Group authorizes a written referral to the Non–Plan Physician (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section) and the drug, supply, or supplement is covered as part of that referral
  - Non–Plan Physicians if the prescription was obtained as part of covered Emergency Services and Care, Post-Stabilization Care, or Out-of-Area Urgent Care (if you fill the prescription at a Plan

Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described in the "Post-Service Claims and Appeals" section)

- Non–Plan Providers that are not providers of Emergency Services and Care or Out-of-Area Urgent Care if the prescription is for COVID-19 therapeutics (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described in the "Post-Service Claims and Appeals" section)

Note: If you obtain a prescription from a Non-Plan Provider related to dental care or for COVID-19 therapeutics as described above, we do not cover an office visit or any other services from the Non-Plan Provider.

How to obtain covered items

You must obtain covered items at a Plan Pharmacy or through our mail-order service unless you obtain the item from a Non-Plan Provider as part of covered Emergency Services and Care, Post-Stabilization Care, or Out-of-Area Urgent Care or a Non-Plan Provider prescribes COVID-19 therapeutics for you.

For the locations of Plan Pharmacies, refer to our Provider Directory or call Member Services.

Refills

You may be able to order refills at a Plan Pharmacy, through our mail-order service, or through our website at **kp.org/rxrefill**. A Plan Pharmacy can give you more information about obtaining refills, including the options available to you for obtaining refills. For example, a few Plan Pharmacies don't dispense refills and not all drugs can be mailed through our mail-order service. Please check with a Plan Pharmacy if you have a question about whether your prescription can be mailed or obtained at a Plan Pharmacy. Items available through our mail-order service are subject to change at any time without notice.

Day supply limit

The prescribing physician or dentist determines how much of a drug, supply, item, or supplement to prescribe. For purposes of day supply coverage limits, Plan Physicians determine the amount of an item that constitutes a Medically Necessary 30- or 100-day supply (or 365-day supply if the item is a hormonal contraceptive) for you. Upon payment of the Cost Share specified in the "Outpatient pharmacy Services" section of the "Cost Share Summary," you will receive the supply prescribed up to the day supply limit specified in this section or in the drug formulary for your plan (see "About the drug formulary" below). The maximum you may receive at one time of a covered item, other than a hormonal contraceptive, is either one 30-day supply in a 30-day period or one 100-day supply in a 100-day period. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantities that exceed the day supply limit.

If your plan includes coverage for hormonal contraceptives, the maximum you may receive at one time of contraceptive drugs is a 365-day supply. To obtain a 365-day supply, talk to your prescribing provider. Refer to the "Cost Share Summary" section of this *EOC* to find out if your plan includes coverage for hormonal contraceptives.

If your plan includes coverage for sexual dysfunction drugs, the maximum you may receive at one time of episodic drugs prescribed for the treatment of sexual dysfunction disorders is eight doses in any 30-day period or up to 27 doses in any 100-day period. Refer to the "Cost Share Summary" section of this *EOC* to find out if your plan includes coverage for sexual dysfunction drugs.

The pharmacy may reduce the day supply dispensed at the Cost Share specified in the "Outpatient pharmacy Services" section of the "Cost Share Summary" for any drug to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan Pharmacy can tell you if a drug you take is one of these drugs).

About the drug formulary

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

Formulary exception process
Drug formulary guidelines allow you to obtain a non-formulary Prescription Drug (those not listed on our drug formulary for your condition) if it would otherwise be covered by your plan, as described above, and it is Medically Necessary. If you disagree with a Health Plan determination that a non-formulary Prescription Drug is not covered, you may file a grievance as described in the "Dispute Resolution" section.

Continuity drugs
If this *EOC* is amended to exclude a drug that we have been covering and providing to you under this *EOC*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration.

About drug tiers

Drugs for your plan are categorized into tiers as described in the table below (your plan doesn't have a Tier 3). Your Cost Share for covered items may vary based on the tier. Refer to "Outpatient pharmacy Services" in the "Cost Share Summary" section of this *EOC* for Cost Share for items covered under this section. Refer to the drug formulary to find out which tier a particular drug is on and for the definition of "generic drug," "brand-name drug," and "specialty drug."

Tier	Description
Tier 1	Most generic drugs, supplies and supplements (also includes certain brand-name drugs, supplies, and supplements)
Tier 2	Most brand-name drugs, supplies, and supplements (also includes certain generic drugs, supplies, and supplements)
Tier 4	High-cost brand-name or generic drugs, supplies, and supplements (sometimes called "specialty drugs")

These tiers apply to formulary and non-formulary drugs, supplies and supplements. If you need help determining whether a formulary or non-formulary drug, supply, or supplement is categorized as Tier 1, Tier 2, or Tier 4, please call Member Services. Note: Non-formulary drugs are not covered unless Medically Necessary as described under "Formulary exception process" in the "About the drug formulary" section above.

General rules about coverage and your Cost Share

We cover Prescription Drugs listed under "Outpatient pharmacy Services" in the "Cost Share Summary" section in accord with the requirements in this "Outpatient Pharmacy Services" section:

- Drugs for which a prescription is required by law
- Certain over-the-counter drugs and items (drugs and items that do not require a prescription by law) if they are listed on our drug formulary and prescribed by a Plan Physician, except a prescription is not required for over-the-counter contraceptives
- Disposable needles and syringes needed for injecting covered drugs and supplements
- Inhaler spacers needed to inhale covered drugs

Note:

- If Charges for the drug, supply, or supplement are less than the Copayment, you will pay the lesser amount, subject to any applicable deductible or out-of-pocket maximum
- Items can change tier at any time, in accord with formulary guidelines, which may impact your Cost Share (for example, if a brand-name drug is added to the specialty drug list, you will pay the Cost Share that applies to drugs on Tier 4, not the Cost Share for drugs on Tier 2)

Schedule II drugs
You or the prescribing provider can request that the pharmacy dispense less than the prescribed amount of a covered oral, solid dosage form of a Schedule II drug (your Plan Pharmacy can tell you if a drug you take is one of these drugs). Your Cost Share will be prorated based on the amount of the drug that is dispensed. If the pharmacy does not prorate your Cost Share, we will send you a refund for the difference.

Mail-order service
Prescription refills can be mailed within 3 to 5 days at no extra cost for standard U.S. postage. The appropriate Cost Share (according to your drug coverage) will apply and must be charged to a valid credit card.

You may request mail-order service in the following ways:

- To order online, visit **kp.org/rxrefill** (you can register for a secure account at **kp.org/registernow**) or use the KP app from your smartphone or other mobile device
- Call the pharmacy phone number highlighted on your prescription label and select the mail delivery option

- On your next visit to a Kaiser Permanente pharmacy, ask our staff how you can have your prescriptions mailed to you

Note: Restrictions and limitations apply. For example, not all drugs can be mailed and we cannot mail drugs to all states.

Manufacturer coupon program
For Prescription Drugs or items that are covered under this "Outpatient Pharmacy Services" section and obtained at a Plan Pharmacy, you may be able to use approved manufacturer coupons as payment for the Cost Share that you owe, as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire amount of your Cost Share for your prescription. When you use an approved coupon for payment of your Cost Share, the coupon amount and any additional payment that you make will accumulate to your out-of-pocket maximum if applicable. Refer to the "Cost Share Summary" section of this *EOC* to find your applicable out-of-pocket maximum amount and to learn which drugs and items apply to the maximum. Certain health plan coverages are not eligible for coupons. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at **kp.org/rxcoupons**.

Base drugs, supplies, and supplements
Cost Share for the following items may be different than other drugs, supplies, and supplements. Refer to "Base drugs, supplies, and supplements" in the "Cost Share Summary" section of this *EOC*:

- Certain drugs for the treatment of life-threatening ventricular arrhythmia
- Drugs for the treatment of tuberculosis
- Elemental dietary enteral formula when used as a primary therapy for regional enteritis
- Hematopoietic agents for dialysis
- Hematopoietic agents for the treatment of anemia in chronic renal insufficiency
- Human growth hormone for long-term treatment of pediatric patients with growth failure from lack of adequate endogenous growth hormone secretion
- Immunosuppressants and ganciclovir and ganciclovir prodrugs for the treatment of cytomegalovirus when prescribed in connection with a transplant
- Phosphate binders for dialysis patients for the treatment of hyperphosphatemia in end stage renal disease

Formulas and food
We cover the following outpatient formulas and food:

- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)
- Medically necessary pasteurized human milk when prescribed by a Plan Provider and obtained from a designated licensed tissue bank. The day supply dispensed may vary based on availability. You may have to pay for the human milk and file a claim for reimbursement. For information on how to file a claim, please see "Initial Claims" in the "Post-Service Claims and Appeals" section
- Elemental dietary enteral formula as described under "Base drugs" in this "Outpatient Pharmacy Services" section
- Enteral formula as described under "Prosthetic and Orthotic Services" in this "Benefits" section

For the following Services, refer to these sections

- Administered contraceptives (refer to "Reproductive Health Services")
- Drugs prescribed for abortion or abortion-related Services (refer to "Reproductive Health Services")
- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "Durable Medical Equipment ("DME") for Home Use")
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")
- Drugs prescribed for pain control and symptom management of the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Durable medical equipment used to administer drugs (refer to "Durable Medical Equipment ("DME") for Home Use")
- Outpatient administered drugs that are not abortion or abortion-related Services or contraceptives (refer to "Administered Drugs and Products")

Outpatient Surgery and Outpatient Procedures

We cover the following outpatient care Services:

- Outpatient surgery

- Outpatient procedures (including imaging and diagnostic Services) when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or in any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Outpatient procedures (including imaging and diagnostic Services) that do not require a licensed staff member to monitor your vital signs (refer to the section that would otherwise apply for the procedure; for example, for radiology procedures that do not require a licensed staff member to monitor your vital signs, refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

Preventive Services

We cover a variety of Preventive Services from Plan Providers, as listed on our website at **kp.org/prevention**, including the following:

- Services recommended by the United States Preventive Services Task Force with rating of "A" or "B." The complete list of these services can be found at **uspreventiveservicestaskforce.org**
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. The complete list of recommended immunizations can be found at **cdc.gov**
- Preventive services recommended by the Health Resources and Services Administration and incorporated into the Affordable Care Act. The complete list of these services can be found at **hrsa.gov/womens-guidelines**

Note: We cover immunizations to prevent COVID-19 that are administered in a Plan Medical Office or by a Non-Plan Provider. If you obtain this immunization from a Non-Plan Provider (except for providers of Emergency Services and Care or Out-of-Area Urgent Care), we do not cover an office visit or any other services from the Non-Plan Provider other than administration of the vaccine.

The list of Preventive Services recommended by the above organizations is subject to change. These Preventive Services are subject to all coverage requirements described in this "Benefits" section and all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.

If you are enrolled in a grandfathered plan, certain preventive items listed on our website, such as over-the-counter drugs, may not be covered. Refer to the "Certain preventive items" table in the "Cost Share Summary" section of this *EOC* for coverage information. If you have questions about Preventive Services, please call Member Services.

Note: Preventive Services help you stay healthy, before you have symptoms. If you have symptoms, you may need other care, such as diagnostic or treatment Services. If you receive any other covered Services that are not Preventive Services before, during, or after a visit that includes Preventive Services, you will pay the applicable Cost Share for those other Services. For example, if laboratory tests or imaging Services ordered during a preventive office visit are not Preventive Services, you will pay the applicable Cost Share for those Services.

For the following Services, refer to these sections

- Family planning counseling, consultations, and sterilization Services (refer to "Reproductive Health Services")
- Health education programs (refer to "Health Education")
- Milk pumps and lactation supplies (refer to "Lactation supplies" under "Durable Medical Equipment ("DME") for Home Use")
- Prescription Drugs that are Preventive Services (refer to "Outpatient Pharmacy Services")

Prosthetic and Orthotic Devices

Prosthetic and orthotic devices coverage rules

We cover the prosthetic and orthotic devices specified in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select
- The item has been approved for you through the Plan's prior authorization process, as described in

"Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section

- The Services are provided inside your Service Area

Coverage includes fitting and adjustment of these devices, their repair or replacement, and Services to determine whether you need a prosthetic or orthotic device. If we cover a replacement device, then you pay the Cost Share that you would pay for obtaining that device.

Covered prosthetic and orthotic devices do not include the following services:

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Nonrigid supplies, such as elastic stockings and wigs, except as otherwise described above in this "Prosthetic and Orthotic Devices" section
- Comfort, convenience, or luxury equipment or features
- Repair or replacement of device due to loss, theft, or misuse
- Shoes, shoe inserts, arch supports, or any other footwear, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications
- Prosthetic and orthotic devices not intended for maintaining normal activities of daily living (including devices intended to provide additional support for recreational or sports activities)

Base prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the items described in this "Base prosthetic and orthotic devices" section.

Internally implanted devices

We cover prosthetic and orthotic devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if they are implanted during a surgery that we are covering under another section of this "Benefits" section.

For internally implanted prosthetic and orthotic devices, you pay the Cost Share for the procedure to implant the device. For example, see "Outpatient Surgery and Outpatient Procedures" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for Outpatient Surgery.

External devices

We cover the following external prosthetic and orthotic devices:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- After Medically Necessary removal of all or part of a breast:
  - ♦ prostheses, including custom-made prostheses when Medically Necessary
  - ♦ up to three brassieres required to hold a prosthesis in any 12-month period
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Enteral pump and supplies
- Tracheostomy tube and supplies
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

Supplemental prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the following items:

- Prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity
- Rigid and semi-rigid orthotic devices required to support or correct a defective body part

For the following Services, refer to these sections

- Eyeglasses and contact lenses, including contact lenses to treat aniridia or aphakia (refer to "Vision Services for Adult Members" and "Vision Services for Pediatric Members")
- Hearing aids other than internally implanted devices described in this section (refer to "Hearing Services")
- Injectable implants (refer to "Administered Drugs and Products")

Reconstructive Surgery

We cover the following reconstructive surgery Services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Plan Physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible
- Following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

Covered reconstructive surgery does not include the following services:

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance

For covered Services related to reconstructive surgery that you receive, you will pay the Cost Share you would pay if the Services were not related to reconstructive surgery. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services, and see "Outpatient surgery and outpatient procedures" in the "Cost Share Summary" for the Cost Share that applies for outpatient surgery.

For the following Services, refer to these sections

- Dental and orthodontic Services that are an integral part of reconstructive surgery for cleft palate (refer to "Dental and Orthodontic Services")
- Office visits not described in the "Reconstructive Surgery" section (refer to "Office Visits")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Prescription Drugs (refer to "Outpatient Pharmacy Services")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Telehealth Visits (refer to "Telehealth Visits")

Rehabilitative and Habilitative Services

We cover the Services described in this "Rehabilitative and Habilitative Services" section if all of the following requirements are met:

- The Services are to address a health condition
- The Services are to help you keep, learn, or improve skills and functioning for daily living
- You receive the Services at a Plan Facility unless a Plan Physician determines that it is Medically Necessary for you to receive the Services in another location

We cover the following Services:

- Individual outpatient physical, occupational, and speech therapy
- Group outpatient physical, occupational, and speech therapy
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program

Covered rehabilitative and habilitative Services do not include the following services:

- Items and services that are not health care items and services (for example, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including vocational training)

For the following Services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder (refer to "Mental Health Services")
- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Home health care (refer to "Home Health Care")
- Office visits that are not physical, occupational, and speech therapy visits (refer to "Office Visits")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Physical, occupational, and speech therapy provided during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Reproductive Health Services

Family planning Services

We cover the following Services when provided for family planning purposes:

- Family planning counseling
- Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") and office visits related to their insertion, removal, and management when provided to prevent pregnancy
- Sterilization procedures for Members assigned female at birth
- Sterilization procedures for Members assigned male at birth

Plan Doula services

If you are pregnant or were pregnant within the last 12 months and want Plan Doula services, talk to your care team. We cover the following Plan Doula services before, during, or after childbirth, miscarriage, stillbirth, and abortion:

- One initial visit (up to 90 minutes)
- Up to eight visits that may be provided in any combination of prenatal and postpartum visits (up to 60 minutes each)
- Support during labor and delivery

Up to two additional postpartum visits may be available (up to 180 minutes each).

Covered Plan Doula services do not include the following services:

- Clinical or medical Services (such as taking blood pressure or temperature, fetal heart tone checks, vaginal examinations, or postpartum clinical care)
- Assistance with activities of daily living
- Alternative or complementary modalities (such as aromatherapy, childbirth education, massage therapy, or placenta encapsulation)
- Yoga
- Birthing ceremonies
- Over-the-counter supplies or drugs
- Home birth
- Belly binding (traditional or ceremonial)
- Massage (maternal or infant)
- Photography
- Placenta encapsulation
- Vaginal steams
- Group classes on baby wearing

For information on how to find a doula, go to **kp.org/doulacare**.

Abortion and abortion-related Services

We cover the following Services:

- Surgical abortion
- Prescription Drugs, in accord with our drug formulary guidelines
- Abortion-related Services

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Fertility Services (refer to "Fertility Services")
- Office visits related to injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") when provided for medical reasons other than to prevent pregnancy (refer to "Office Visits")
- Outpatient administered drugs that are not contraceptives (refer to "Administered Drugs and Products")
- Outpatient laboratory and imaging services associated with family planning services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient contraceptive drugs and devices (refer to "Outpatient Pharmacy Services")
- Outpatient surgery and outpatient procedures when provided for medical reasons other than to prevent pregnancy (refer to "Outpatient Surgery and Outpatient Procedures")

Services in Connection with a Clinical Trial

We cover Services you receive in connection with a clinical trial if all of the following requirements are met:

- We would have covered the Services if they were not related to a clinical trial
- You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening

condition, as determined in one of the following ways:

- ♦ a Plan Provider makes this determination
- ♦ you provide us with medical and scientific information establishing this determination

- If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live
- The clinical trial is an Approved Clinical Trial

For covered Services related to a clinical trial, you will pay the Cost Share you would pay if the Services were not related to a clinical trial. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services.

Skilled Nursing Facility Care

Inside your Service Area, we cover skilled inpatient Services in a Plan Skilled Nursing Facility. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment if Skilled Nursing Facilities ordinarily furnish the equipment (refer to "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)
- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Whole blood, red blood cells, plasma, platelets, and their administration
- Medical supplies
- Behavioral Health Treatment for Autism Spectrum Disorder
- Physical, occupational, and speech therapy
- Respiratory therapy

For the following Services, refer to these sections

- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient physical, occupational, and speech therapy (refer to "Rehabilitative and Habilitative Services")

Substance Use Disorder Treatment

We cover Services specified in this "Substance Use Disorder Treatment" section only when the Services are for the prevention, diagnosis, or treatment of Substance Use Disorders. A "Substance Use Disorder" is a substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Outpatient substance use disorder treatment

We cover the following Services for treatment of substance use disorders:

- Day-treatment programs
- Individual and group substance use disorder counseling
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms
- Methadone maintenance treatment at a licensed treatment center approved by Medical Group

Residential treatment

Inside your Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized substance use disorder treatment, the Services are generally and customarily provided by a substance use disorder residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group substance use disorder counseling
- Medical services
- Medication monitoring
- Room and board
- Social services
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in

accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Pharmacy Services" in this "Benefits" section)

- Discharge planning

Inpatient detoxification

We cover hospitalization in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Services from Non-Plan Providers

If we are not able to offer an appointment with a Plan Provider within required geographic and timely access standards, we will offer to refer you to a Non-Plan Provider (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Additionally, we cover Services provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services (collectively, "988 Services") for medically necessary treatment of a mental health or substance use disorder without prior authorization until the condition is stabilized, as required by state law. After the mental health or substance use disorder condition has been stabilized, post-stabilization care from Non-Plan Providers is subject to prior authorization as described under "Post-Stabilization Care" in the "Emergency Services" section.

For these referral Services and 988 Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

For the following Services, refer to these sections

- Drugs administered by a substance use disorder treatment provider to treat a substance use disorder (refer to "Administered Drugs")
- Outpatient laboratory, including drug testing (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient self-administered drugs (refer to "Outpatient Pharmacy Services")
- Telehealth Visits (refer to "Telehealth Visits")

Telehealth Visits

Telehealth Visits are intended to make it more convenient for you to receive covered Services, when a Plan Provider determines it is medically appropriate for your medical condition. You may receive covered Services via Telehealth Visits, when available and if the Services would have been covered under this *EOC* if provided in person. You are not required to use Telehealth Visits, and you may choose to receive in-person Services from a Plan Provider instead. Some Plan Providers offer Services exclusively through a telehealth technology platform and have no physical location at which you can receive Services. If you receive covered Services from these Plan Providers, you may access your medical record of the Telehealth Visit and, unless you object, such information will be added to your Health Plan electronic medical record and shared with your Primary Care Physician.

We cover the following types of Telehealth Visits with Primary Care Physicians, Non-Physician Specialists, and Physician Specialists:

- Interactive video visits
- Scheduled telephone visits

Transplant Services

We cover transplants of organs, tissue, or bone marrow if the Medical Group provides a written referral for care to a transplant facility as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

After the referral to a transplant facility, the following applies:

- If either the Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover Services you receive before that determination is made
- Health Plan, Plan Hospitals, the Medical Group, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with our guidelines for Services for living transplant donors, we provide certain donation-related Services for a donor, or an individual identified by the Medical Group as a potential donor, whether or not the donor is a Member. These Services must be directly related to a covered transplant for you, which may include certain Services for harvesting the organ, tissue, or bone marrow and for treatment of

complications. Please call Member Services for questions about donor Services

For covered transplant Services that you receive, you will pay the Cost Share you would pay if the Services were not related to a transplant. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services. We provide or pay for donation-related Services for actual or potential donors (whether or not they are Members) in accord with our guidelines for donor Services at **no charge**.

For the following Services, refer to these sections

- Dental Services that are Medically Necessary to prepare for a transplant (refer to "Dental and Orthodontic Services")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Prescription Drugs (refer to "Outpatient Pharmacy Services")

Vision Services for Adult Members

For the purpose of this "Vision Services for Adult Members" section, an "Adult Member" is a Member who is age 19 or older and is not a Pediatric Member, as defined under "Vision Services for Pediatric Members" in this "Benefits" section. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1.

We cover the following for Adult Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye

Optical Services

We cover the Services described in this "Optical Services" section when received from Plan Medical Offices or Plan Optical Sales Offices. Covered optical Services do not include the following services:

- Eyeglass or contact lens adornment, such as engraving, faceting, or jeweling
- Items that do not require a prescription by law (other than eyeglass frames), such as eyeglass holders, eyeglass cases, and repair kits
- Lenses and sunglasses without refractive value, except as described in this "Vision Services for Adult Members" section
- Low vision devices
- Replacement of lost, broken, or damaged contact lenses, eyeglass lenses, and frames
- Items and services to reshape the eye or correct refractive defects of the eyes

The date we provide an Allowance toward (or otherwise cover) an item described in this "Optical Services" section is the date on which you order the item. For example, if we last provided an Allowance toward an item you ordered on May 1, 2024, and if we provide an Allowance not more than once every 24 months for that type of item, then we would not provide another Allowance toward that type of item until on or after May 1, 2026. You can use the Allowances under this "Optical Services" section only when you first order an item. If you use part but not all of an Allowance when you first order an item, you cannot use the rest of that Allowance later.

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist
- For aphakia (absence of the crystalline lens of the eye), we cover up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist
- For other specialty contact lenses that will provide a significant improvement in your vision not obtainable with eyeglass lenses, we cover either one pair of contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses (up to six months, including fitting and dispensing) in any 24-month period

Eyeglasses and contact lenses

We provide a single Allowance toward the purchase price of any or all of the following not more than once every 24 months when a physician or optometrist

prescribes an eyeglass lens (for eyeglass lenses and frames) or contact lens (for contact lenses). Refer to "Vision Services for Adult Members" in the "Cost Share Summary" section of this *EOC* for your Allowance amount.

- Eyeglass lenses when a Plan Provider puts the lenses into a frame
  - ♦ we cover a clear balance lens when only one eye needs correction
  - ♦ we cover tinted lenses when Medically Necessary to treat macular degeneration or retinitis pigmentosa
- Eyeglass frames when a Plan Provider puts two lenses (at least one of which must have refractive value) into the frame
- Contact lenses, fitting, and dispensing

We will not provide the Allowance if we have provided an Allowance toward (or otherwise covered) eyeglass lenses or frames within the previous 24 months.

Replacement lenses

If you have a change in prescription of at least .50 diopter in one or both eyes within 12 months of the initial point of sale of an eyeglass lens or contact lens that we provided an Allowance toward (or otherwise covered) we will provide an Allowance toward the purchase price of a replacement item of the same type (eyeglass lens, or contact lens, fitting, and dispensing) for the eye that had the .50 diopter change. Refer to "Vision Services for Adult Members" in the "Cost Share Summary" section of this *EOC* for your Allowance amount.

Low vision devices

Low vision devices (including fitting and dispensing) are not covered under this *EOC*.

For the following Services, refer to these sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than Services covered under this "Vision Services for Adult Members" section, such as outpatient surgery and Prescription Drugs (refer to the applicable heading in this "Benefits" section)

Vision Services for Pediatric Members

For the purpose of this "Vision Services for Pediatric Members" section, a "Pediatric Member" is a Member from birth through the end of the month of their 19th birthday. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1 and your last minute as a Pediatric Member will be 11:59 p.m. on June 30.

We cover the following for Pediatric Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye

Optical Services

We cover the Services described in this "Optical Services" section when received from Plan Medical Offices or Plan Optical Sales Offices. Covered optical Services do not include the following services:

- Eyeglass or contact lens adornment, such as engraving, faceting, or jeweling
- Items that do not require a prescription by law (other than eyeglass frames), such as eyeglass holders, eyeglass cases, and repair kits
- Lenses and sunglasses without refractive value, except as described in this "Vision Services for Pediatric Members" section
- Low vision devices
- Replacement of lost, broken, or damaged contact lenses, eyeglass lenses, and frames
- Items and services to reshape the eye or correct refractive defects of the eye

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist
- For aphakia (absence of the crystalline lens of the eye), we cover up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist

- For other specialty contact lenses that will provide a significant improvement in your vision not obtainable with eyeglass lenses, we cover either one pair of contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses (up to six months, including fitting and dispensing) in any 24-month period

Eyeglasses and contact lenses
We provide a single Allowance toward the purchase price of any or all of the following not more than once every 24 months when a physician or optometrist prescribes an eyeglass lens (for eyeglass lenses and frames) or contact lens (for contact lenses). Refer to "Vision Services for Pediatric Members" in the "Cost Share Summary" section of this *EOC* for your Allowance amount.

- Eyeglass lenses when a Plan Provider puts the lenses into a frame
  - ♦ we cover a clear balance lens when only one eye needs correction
  - ♦ we cover tinted lenses when Medically Necessary to treat macular degeneration or retinitis pigmentosa
- Eyeglass frames when a Plan Provider puts two lenses (at least one of which must have refractive value) into the frame
- Contact lenses, fitting, and dispensing

We will not provide the Allowance if we have provided an Allowance toward (or otherwise covered) eyeglass lenses or frames within the previous 24 months.

Replacement lenses
If you have a change in prescription of at least .50 diopter in one or both eyes at least 12 months after the date we dispensed eyeglass lenses of the type described in this "Vision Services for Pediatric Members" section, we will cover a replacement Regular Eyeglass Lens for the eye that had the .50 diopter change.

Low vision devices
Low vision devices (including fitting and dispensing) are not covered under this *EOC*.

For the following Services, refer to these sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than Services covered under this "Vision Services for Pediatric Members" section, such as outpatient surgery and Prescription Drugs (refer to the applicable heading in this "Benefits" section)

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

This Kaiser Permanente Traditional HMO Plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in this *EOC*.

These exclusions and limitations do not apply to Medically Necessary basic health care services required to be covered under California or federal law, including but not limited to Medically Necessary Treatment of a Mental Health or Substance Use Disorder, as well as preventive services required to be covered under California or federal law.

These exclusions and limitations do not apply when covered by this Kaiser Permanente Traditional HMO Plan or required by law.

Acupuncture services
This Kaiser Permanente Traditional HMO Plan does not cover acupuncture services, except as described in this *EOC* under "Office Visits" in the "Benefits" section, or as required by law, unless you have coverage for supplemental acupuncture Services as described in an amendment to this *EOC*.

Chiropractic services
This Kaiser Permanente Traditional HMO Plan does not cover chiropractic services, except as required by law, unless you have coverage for supplemental chiropractic Services as described in an amendment to this *EOC*.

Clinical trials
This Kaiser Permanente Traditional HMO Plan does not cover clinical trials, except Approved Clinical Trials as described in this *EOC* under "Services in Connection with a Clinical Trial" in the "Benefits" section, or as required by law.

Coverage of Approved Clinical Trials does not include the following:

- The investigational drug, item, or service itself

- Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member
- Drugs, items, devices, and services specifically excluded from coverage in this *EOC*, except for drugs, items, devices, and services required to be covered pursuant to state and federal law
- Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor

This exclusion does not limit, prohibit, or modify a Member's rights to the Experimental Services or Investigational Services independent review process as described in this *EOC* under "Experimental Services or Investigational Services" in this "Exclusion" section, or to Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) as described in this *EOC* under "Independent Medical Review ('IMR') in the "Dispute Resolution" section.

Cosmetic services

This Kaiser Permanente Traditional HMO Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function, except as required by law.

This Kaiser Permanente Traditional HMO Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth, except as required by law.

This cosmetic services exclusion does not apply to the following:

- Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages, as described in the "Benefits" section
- Reconstructive surgery as described in this *EOC* under "Reconstructive Surgery" in the "Benefits" section
- For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in this *EOC* under "Reconstructive Surgery" in the "Benefits" section
- Testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after removal of all or part of a breast, and prostheses to replace all or part of an external facial body part as described in this *EOC* under "Prosthetic and Orthotic Devices" in the "Benefits" section

Custodial or domiciliary care

This Kaiser Permanente Traditional HMO Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, except as required by law.

This exclusion does not apply to the following:

- Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals (see "Hospice Care," "Home Health Care," "Skilled Nursing Facility Care," "Hospital Inpatient Services," "Mental Health Services," and "Substance Using Disorder Treatment" in the "Benefits" section)
- Assistance with activities of daily living that is provided as part of covered hospice, home health, skilled nursing facility, or inpatient hospital care (see "Hospice Care," "Home Health Care," "Skilled Nursing Facility Care," "Hospital Inpatient Services," "Mental Health Services," and "Substance Using Disorder Treatment" in the "Benefits" section)
- Custodial care provided in a healthcare facility (see "Hospice Care," "Skilled Nursing Facility Care," "Hospital Inpatient Services," "Mental Health Services," and "Substance Using Disorder Treatment" in the "Benefits" section)

Dental services

This Kaiser Permanente Traditional HMO Plan does not cover dental services or supplies, except as described in this *EOC* under "Dental and Orthodontic Services" and "Injury to Teeth" in the "Benefits" section, or as required by law.

Dietary or nutritional supplements

This Kaiser Permanente Traditional HMO Plan does not cover dietary or nutritional supplements, except as required by law.

Disposable supplies for home use

This Kaiser Permanente Traditional HMO Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in this *EOC*

under “Durable Medical Equipment (‘DME’) for Home Use,” “Home Health Care,” “Hospice Care,” “Ostomy and Urological Supplies,” and “Outpatient Pharmacy Services” in the “Benefits” section, or as required by law.

Experimental Services or Investigational Services

This Kaiser Permanente Traditional HMO Plan does not cover Experimental Services or Investigational Services, except as described below, or as required by law.

“Experimental Services” are drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

“Investigational Services” are those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress and all of the following are true:

- Testing is not complete
- The efficacy and safety of such services in human subjects are not yet established
- The service is not in wide usage

The determination that a service is an Experimental Service or Investigational Service is based on:

- Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration)
- Consultation with provider organizations, academic and professional specialists pertinent to the specific service
- Reference to current medical literature

However, if the health plan denies or delays coverage for your requested service on the basis that it is an Experimental Service or Investigational Service and you meet all the qualifications set out below, the health plan must provide an external, independent review.

Qualifications

- You must have a Life-Threatening or Seriously Debilitating condition
- Your Health Care Provider must certify to the health plan that you have a Life-Threatening or Seriously Debilitating condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the health plan
- Either (a) your Health Care Provider, who has a contract with or is employed by the health plan, has recommended a drug, device, procedure, or other therapy that the Health Care Provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your Health Care Provider, who is a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy
- You have been denied coverage by the health plan for the recommended or requested service
- If not for the health plan’s determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered

External, Independent Review Process

If the health plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the health plan will notify you within five business days of its decision and your opportunity to request external review of the health plan’s decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the health plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled.

DMHC’s Independent Medical Review (“IMR”)

This exclusion does not limit, prohibit, or modify a Member’s rights to an IMR from the DMHC as described in this *EOC* in the “Dispute Resolution” section. In certain circumstances, you do not have to participate in the health plan’s grievance or appeals process before requesting an IMR of denials for Experimental Services or Investigational Services. In such cases you may immediately contact the DMHC to request an IMR of this denial as described in this *EOC* in the “Dispute Resolution” section.

Hearing aids

This Kaiser Permanente Traditional HMO Plan does not cover hearing aids, except as described in this *EOC* under "Hearing Services" in the "Benefits" section, or as required by law.

Non-licensed or non-certified providers

This Kaiser Permanente Traditional HMO Plan does not cover treatments or services rendered by a non-licensed or non-certified provider, except doula services as described in this *EOC* under "Reproductive Health Services" in the "Benefits" section, or as required by law.

This exclusion also does not apply to Medically Necessary treatment of a Mental Health or Substance Use Disorder furnished or delivered by, or under the direction of, a Health Care Provider acting within the scope of practice of the provider's license or certification under applicable state law.

Personal or comfort items

This Kaiser Permanente Traditional HMO Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.

Prescription Drugs / Outpatient Prescription Drugs

This Kaiser Permanente Traditional HMO Plan does not cover the following Prescription Drugs, except as described in this *EOC* under "Outpatient Pharmacy Services" or "Preventive Services" in the "Benefits" section or as required by law:

- When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function
- When prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease
- When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of Class III or severe obesity. We may require Members who are prescribed drugs for Class III or severe obesity to be enrolled in a covered comprehensive weight loss program, for a reasonable period of time prior to or concurrent with receiving the Prescription Drug
- When prescribed solely for the purpose of shortening the duration of the common cold
- Prescription Drugs available over the counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This exclusion does not apply to any of the following:
  - ♦ insulin
  - ♦ over-the-counter drugs as covered under preventive services, for example, over-the-counter FDA-approved contraceptive drugs
  - ♦ over-the-counter drugs for reversal of an opioid overdose
  - ♦ an entire class of Prescription Drugs when one drug within that class becomes available over the counter
- Replacement of lost or stolen drugs
- Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a health plan or a plan provider, except when coverage is otherwise required in the context of Emergency Services and Care

Private duty nursing

This Kaiser Permanente Traditional HMO Plan does not cover private duty nursing in the home, hospital, or long-term care facility, except as required by law.

Reversal of voluntary sterilization

This Kaiser Permanente Traditional HMO Plan does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications as described in the "Benefits" section, except as required by law.

Routine physical examination

This Kaiser Permanente Traditional HMO Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, or other non-preventive purpose, except as required by law.

Surrogate pregnancy

This Kaiser Permanente Traditional HMO Plan does not cover testing, services, or supplies for a person who is not covered under this *EOC* for a surrogate pregnancy, except as required by law.

Therapies

This Kaiser Permanente Traditional HMO Plan does not cover the following physical and occupational therapies, except as described in this *EOC* under "Rehabilitative and Habilitative Services" in the "Benefits" section, or as required by law:

- Massage therapy, unless it is a component of a treatment plan
- Training or therapy for the treatment of learning disabilities or behavioral problems
- Social skills training or therapy
- Vocational, educational, recreational, art, dance, music, or reading therapy

Travel and lodging

This Kaiser Permanente Traditional HMO Plan does not cover transportation, mileage, lodging, meals, and other Member-related travel costs, except for licensed ambulance or psychiatric transport as described in this *EOC* under "Ambulance Services" in the "Benefits" section or as described under "Travel and Lodging for Certain Services" in the 'How to Obtain Services" section.

Vision care

This Kaiser Permanente Traditional HMO Plan does not cover vision services, except as described in this *EOC* under "Vision Services for Adult Members" and "Vision Services for Pediatric Members" in the "Benefits" section, or as required by law.

Weight control programs and exercise programs

This Kaiser Permanente Traditional HMO Plan does not cover weight control programs and exercise programs, except as described in this *EOC* under "Health Education" in the "Benefits" section, or as required by law.

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC*, such as a major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor dispute. Under these circumstances, if you have an Emergency Medical Condition or Psychiatric Emergency Medical Condition, call 911 or go to the nearest emergency department as described under "Emergency Services" in the "How to Obtain Services" section, and we will provide coverage and reimbursement as described in that section.

Coordination of Benefits

The Services covered under this *EOC* are subject to coordination of benefits rules.

Coverage other than Medicare coverage

If you have medical or dental coverage under another plan that is subject to coordination of benefits, we will coordinate benefits with the other coverage under the coordination of benefits rules of the California Department of Managed Health Care. Those rules are incorporated into this *EOC*.

If both the other coverage and we cover the same Service, the other coverage and we will see that up to 100 percent of your covered medical expenses are paid for that Service. The coordination of benefits rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." The secondary coverage may reduce its payment to take into account payment by the primary coverage. You must give us any information we request to help us coordinate benefits.

If your coverage under this *EOC* is secondary, we may be able to establish a Benefit Reserve Account for you. You may draw on the Benefit Reserve Account during a calendar year to pay for your out-of-pocket expenses for Services that are partially covered by either your other coverage or us during that calendar year. If you are entitled to a Benefit Reserve Account, we will provide you with detailed information about this account.

If you have any questions about coordination of benefits, please call Member Services.

Medicare coverage

If you have Medicare coverage, we will coordinate benefits with the Medicare coverage under Medicare rules. Medicare rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." You must give us any information we request to help us coordinate benefits. Please call Member Services to find out which Medicare rules apply to your situation, and how payment will be handled.

Reductions

Employer responsibility

For any Services that the law requires an employer to provide, we will not pay the employer, and when we

cover any such Services we may recover the value of the Services from the employer.

Government agency responsibility

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

Injuries or illnesses alleged to be caused by other parties

If you obtain a judgment or settlement from or on behalf of another party who allegedly caused an injury or illness for which you received covered Services, you must reimburse us to the maximum extent allowed under California Civil Code Section 3040. The reimbursement due to us is not limited by or subject to the Plan Out-of-Pocket Maximum. Note: This "Injuries or illnesses alleged to be caused by other parties" section does not affect your obligation to pay your Cost Share for these Services.

To the extent permitted or required by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another 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 other 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 (1) against another party, and/or (2) from other types of coverage or sources of payment that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, workers' compensation, and/or personal injury coverages, any other types of medical payments and all other first party types of coverages or sources of payment. The proceeds of any judgment or settlement that you or we obtain and/or payments that you receive 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.

Within 30 days after submitting or filing a claim or legal action against another party, you must send written notice of the claim or legal action to:

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

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the other party, and the other 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 another 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 other party. We may assign our rights to enforce our liens and other rights.

If you have Medicare, Medicare law may apply with respect to Services covered by Medicare.

Surrogacy Arrangements

If you enter into a Surrogacy Arrangement and you or any other payee are entitled to receive monetary compensation under the Surrogacy Arrangement, you must reimburse us for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services") to the maximum extent allowed under California Civil Code Section 3040. Note: This "Surrogacy Arrangements" section does not affect your obligation to pay your Cost Share for these Services. After you surrender a baby to the legal parents, you are not obligated to reimburse us for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical

expenses. To secure our rights, we will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and phone numbers of the other parties to the arrangement
- Names, addresses, and phone numbers of any escrow agent or trustee
- Names, addresses, and phone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receive, including names, addresses, and phone numbers for any health insurance that will cover Services that the baby (or babies) receive
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

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

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy Arrangements" section and to satisfy those rights. You may not agree to waive, release, or reduce our rights under this "Surrogacy Arrangements" section without our prior, written consent.

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

If you have questions about your obligations under this provision, please call Member Services.

U.S. Department of Veterans Affairs

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

Workers' compensation or employer's liability benefits

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

Post-Service Claims and Appeals

This "Post-Service Claims and Appeals" section explains how to file a claim for payment or reimbursement for Services that you have already received. Please use the procedures in this section in the following situations:

- You have received Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 testing, therapeutics, or immunization Services from a Non–Plan Provider and you want us to pay for the Services
- You have received Services from a Non–Plan Provider that we did not authorize (other than Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 testing, therapeutics, or immunization Services) and you want us to pay for the Services

- You want to appeal a denial of an initial claim for payment

Please follow the procedures under "Grievances" in the "Dispute Resolution" section in the following situations:

- You want us to cover Services that you have not yet received
- You want us to continue to cover an ongoing course of covered treatment
- You want to appeal a written denial of a request for Services that require prior authorization (as described under "Medical Group authorization procedure for certain referrals")

Who May File

The following people may file claims:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a claim for you by appointing them in writing as your authorized representative
- A parent may file for their child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the claim
- A court-appointed guardian may file for their ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the claim
- A court-appointed conservator may file for their conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for their principal

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services office at a Plan Facility, on our website at **kp.org,** or by calling Member Services. Your written authorization must accompany the claim. You must pay the cost of anyone you hire to represent or help you.

Supporting Documents

You can request payment or reimbursement orally or in writing. Your request for payment or reimbursement, and any related documents that you give us, constitute your claim.

Claim forms for Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, COVID-19 Services, Plan Doula services, and human milk

To file a claim in writing for Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 testing, therapeutics, or immunization Services, please use our claim form. You can obtain a claim form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

Claims forms for all other Services

To file a claim in writing for all other Services, you may use our grievance form. You can obtain this form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

Other supporting information

When you file a claim, please include any information that clarifies or supports your position. For example, if you have paid for Services, please include any bills and receipts that support your claim. To request that we pay a Non–Plan Provider for Services, include any bills from the Non–Plan Provider. If the Non–Plan Provider states that they will file the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. When appropriate, we will request medical records from Plan Providers on your behalf. If you tell us that you have consulted with a Non–Plan Provider and are unable to provide copies of relevant medical records, we will contact the provider to request a copy of your relevant medical records. We will ask you to provide us a written authorization so that we can request your records.

If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your

claim. To make a request, you should follow the steps in the written notice sent to you about your claim.

Initial Claims

To request that we pay a provider (or reimburse you) for Services that you have already received, you must file a claim. If you have any questions about the claims process, please call Member Services.

Submitting a claim for Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, COVID-19 Services, Plan Doula services, and human milk

You may file a claim (request for payment/reimbursement):

- By visiting **kp.org**, completing an electronic form and uploading supporting documentation;
- By mailing a paper form that can be obtained by visiting **kp.org** or calling Member Services; or
- If you are unable access the electronic form (or obtain the paper form), by mailing the minimum amount of information we need to process your claim:
  - Member/Patient Name and Medical/Health Record Number
  - The date you received the Services
  - Where you received the Services
  - Who provided the Services
  - Why you think we should pay for the Services
  - A copy of the bill, your medical record(s) for these Services, and your receipt if you paid for the Services

Mailing address to submit your claim to Kaiser Permanente:

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

Please call Member Services if you need help filing your claim.

Submitting a claim for all other Services

If you have received any other Services from a Non–Plan Provider that we did not authorize, then as soon as possible after you receive the Services, you must file your claim in one of the following ways:

- By delivering your claim to a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By mailing your claim to a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at **kp.org**

Please call Member Services if you need help filing your claim.

After we receive your claim

We will send you an acknowledgment letter within five days after we receive your claim.

After we review your claim, we will respond as follows:

- If we have all the information we need we will send you a written decision within 30 days after we receive your claim
- If we need more information, we will ask you for the information before the end of the initial 30-day decision period. We will send our written decision no later than 30 days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in our letter, we will make our decision based on the information we have within 30 days after the end of that timeframe

If we pay any part of your claim, we will subtract applicable Cost Share from any payment we make to you or the Non–Plan Provider. You are not responsible for any amounts beyond your Cost Share for covered Emergency Services and Care. If we deny your claim (if we do not agree to pay for all the Services you requested other than the applicable Cost Share), our letter will explain why we denied your claim and how you can appeal.

If you later receive any bills from the Non–Plan Provider for covered Services (other than bills for your Cost Share), please call Member Services for assistance.

Appeals

Claims for Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 Services, Plan Doula services, or human milk from a Non–Plan Provider

If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By mailing your appeal to the Claims Department at the following address:

  Kaiser Foundation Health Plan, Inc.
  Special Services Unit
  P.O. Box 23280
  Oakland, CA 94623
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at **kp.org**

Claims for all other Services from a Non-Plan Provider that we did not authorize

If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By visiting our website at **kp.org**
- By mailing your appeal to any Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- In person at any Member Services office at a Plan Facility or any Plan Provider (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

When you file an appeal, please include any information that clarifies or supports your position. If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should call Member Services.

Additional information regarding claims for all other Services from a Non–Plan Provider that we did not authorize

If we initially denied your request, you must file your appeal within 180 days after the date you received our denial letter. You may send us information including comments, documents, and medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal. Please send all additional information to the address or fax mentioned in your denial letter.

Also, you may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter, sent to you within five days after we receive your appeal. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will review it without regard to whether this information was filed or considered in our initial decision regarding your request for Services. You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our final decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

We will send you a resolution letter within 30 days after we receive your appeal. If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

External Review

You must exhaust our internal claims and appeals procedures before you may request external review unless we have failed to comply with the claims and appeals procedures described in this "Post-Service Claims and Appeals" section. For information about the external review process, see "Independent Medical Review ("IMR")" in the "Dispute Resolution" section.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims

and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at **1-866-444-EBSA** (**1-866-444-3272**)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Dispute Resolution

We are committed to providing you with quality care and with a timely response to your concerns. You can discuss your concerns with our Member Services representatives at most Plan Facilities, or you can call Member Services.

Grievances

This "Grievances" section describes our grievance procedure. A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. If you want to make a claim for payment or reimbursement for Services that you have already received from a Non–Plan Provider, please follow the procedure in the "Post-Service Claims and Appeals" section.

Here are some examples of reasons you might file a grievance:

- You are not satisfied with the quality of care you received from a Plan Provider or a Non-Plan Provider to which you have been referred
- You received a written denial of Services that require prior authorization from the Medical Group and you want us to cover the Services
- You received a written denial for a second opinion or we did not respond to your request for a second opinion in an expeditious manner, as appropriate for your condition
- Your treating physician has said that Services are not Medically Necessary and you want us to cover the Services
- You were told that Services are not covered and you believe that the Services should be covered
- You want us to continue to cover an ongoing course of covered treatment
- You are dissatisfied with how long it took to get Services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility
- You believe you have faced discrimination from providers, staff, or Health Plan
- We terminated your membership and you disagree with that termination

Who may file

The following people may file a grievance:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a grievance for you by appointing them in writing as your authorized representative
- A parent may file for their child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the grievance
- A court-appointed guardian may file for their ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the grievance
- A court-appointed conservator may file for their conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for their principal
- Your physician may act as your authorized representative with your verbal consent to request an urgent grievance as described under "Urgent procedure" in this "Grievances" section

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services office at a Plan Facility, on our website at **kp.org**, or by calling Member Services. Your written authorization must accompany the grievance. You must pay the cost of anyone you hire to represent or help you.

How to file

You can file a grievance orally or in writing. Your grievance must explain your issue, such as the reasons

why you believe a decision was in error or why you are dissatisfied with the Services you received.

Standard Procedure
To file a grievance electronically, use the grievance form on **kp.org**.

To file a grievance orally, call Member Services toll free at **1-800-464-4000** (TTY users call **711**).

To file a grievance in writing, please use our grievance form, which is available on **kp.org** under "Forms & Publications," in person from any Member Services office at a Plan Facility, or from Plan Providers (for addresses, refer to our Provider Directory or call Member Services). You can submit the form in the following ways:

- In person at any Member Services office at a Plan Facility
- By mail to any Member Services office at a Plan Facility

You must file your grievance within 180 days following the incident or action that is subject to your dissatisfaction. You may send us information including comments, documents, and medical records that you believe support your grievance.

Please call Member Services if you need help filing a grievance.

If your grievance involves a request to obtain a non-formulary Outpatient Prescription Drug, we will notify you of our decision within 72 hours. If we do not decide in your favor, our letter will explain why and describe your further appeal rights. For information on how to request a review by an independent review organization, see "Independent Review Organization for Non-Formulary Outpatient Prescription Drug Requests" in this "Dispute Resolution" section.

For all other grievances, we will send you an acknowledgment letter within five days after we receive your grievance. We will send you a resolution letter within 30 days after we receive your grievance. If you are requesting Services, and we do not decide in your favor, our letter will explain why and describe your further appeal rights.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should call Member Services.

Urgent procedure
If you want us to consider your grievance on an urgent basis, please tell us that when you file your grievance. Note: Urgent is sometimes referred to as "exigent." If exigent circumstances exist, your grievance may be reviewed using the urgent procedure described in this section.

You must file your urgent grievance in one of the following ways:

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 1809
  Pleasanton, CA 94566
- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By completing the grievance form on our website at **kp.org**

We will decide whether your grievance is urgent or non-urgent unless your attending Health Care Provider tells us your grievance is urgent. If we determine that your grievance is not urgent, we will use the procedure described under "Standard procedure" in this "Grievances" section. Generally, a grievance is urgent only if one of the following is true:

- Using the standard procedure could seriously jeopardize your life, health, or ability to regain maximum function
- Using the standard procedure would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment
- A physician with knowledge of your medical condition determines that your grievance is urgent
- You have received Emergency Services and Care but have not been discharged from a facility and your request involves admissions, continued stay, or other health care Services
- You are undergoing a current course of treatment using a non-formulary Outpatient Prescription Drug and your grievance involves a request to refill a non-formulary Outpatient Prescription Drug

For most grievances that we respond to on an urgent basis, we will give you oral notice of our decision as soon as your clinical condition requires, but no later than 72 hours after we received your grievance. We will send you a written confirmation of our decision within three days after we received your grievance.

If your grievance involves a request to obtain a non-formulary Outpatient Prescription Drug and we respond to your request on an urgent basis, we will notify you of our decision within 24 hours of your request. For information on how to request a review by an independent review organization, see "Independent Review Organization for Non-Formulary Outpatient Prescription Drug Requests" in this "Dispute Resolution" section.

If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the California Department of Managed Health Care at any time at **1-888-466-2219** (TDD **1-877-688-9891**) without first filing a grievance with us.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should call Member Services.

Additional information regarding pre-service requests for Medically Necessary Services

You may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your grievance file and we will consider it in our decision regarding your pre-service request for Medically Necessary Services.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your grievance is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your grievance file.

Additional information regarding appeals of written denials for Services that require prior authorization

You must file your appeal within 180 days after the date you received our denial letter.

You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your appeal.

Also, you may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will consider it in our decision regarding your appeal.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your appeal is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

Additional information about utilization review determination criteria for mental health Services or substance use disorder treatment

Utilization review determination criteria and any education program materials for individuals making authorization decisions related to mental health Services or substance use disorder treatment are available at **kp.org** at no cost.

Independent Review Organization for Non-Formulary Outpatient Prescription Drug Requests

If you filed a grievance to obtain a non-formulary Outpatient Prescription Drug and we did not decide in your favor, you may submit a request for a review of your grievance by an independent review organization ("IRO"). You must submit your request for IRO review within 180 days of the receipt of our decision letter.

You must file your request for IRO review in one of the following ways:

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 1809
  Pleasanton, CA 94566
- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By completing the grievance form on our website at **kp.org**

For urgent IRO reviews, we will forward to you the independent reviewer's decision within 24 hours. For non-urgent requests, we will forward the independent reviewer's decision to you within 72 hours. If the independent reviewer does not decide in your favor, you may submit a complaint to the Department of Managed Health Care, as described under "Department of Managed Health Care Complaints" in this "Dispute Resolution" section. You may also submit a request for an Independent Medical Review as described under "Independent Medical Review" in this "Dispute Resolution" section.

Department of Managed Health Care Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan toll free at **1-800-464-4000** (TTY users call **711**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Independent Medical Review ("IMR")

Except as described in this "Independent Medical Review ("IMR")" section, you must exhaust our internal grievance procedure before you may request independent medical review unless we have failed to comply with the grievance procedure described under "Grievances" in this "Dispute Resolution" section. If you qualify, you or your authorized representative may have your issue reviewed through the IMR process managed by the California Department of Managed Health Care ("DMHC"). The DMHC determines which cases qualify for IMR. This review is at no cost to you. If you decide not to request an IMR, you may give up the right to pursue some legal actions against us.

You may qualify for IMR if all of the following are true:

- One of these situations applies to you:
  - you have a recommendation from a provider requesting Medically Necessary Services
  - you have received emergency or urgent medical services from a provider who determined the services to be Medically Necessary
  - you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition
- Your request for payment or Services has been denied, modified, or delayed based in whole or in part on a decision that the Services are not Medically Necessary
- You have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for urgent grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and

compelling cases, such as severe pain or potential loss of life, limb, or major bodily function. If we have denied your grievance, you must submit your request for an IMR within six months of the date of our written denial. However, the DMHC may accept your request after six months if they determine that circumstances prevented timely submission

You may also qualify for IMR if the Service you requested has been denied on the basis that it is experimental or investigational as described under "Experimental or investigational denials."

If the DMHC determines that your case is eligible for IMR, it will ask us to send your case to the DMHC's IMR organization. The DMHC will promptly notify you of its decision after it receives the IMR organization's determination. If the decision is in your favor, we will contact you to arrange for the Service or payment.

Experimental or investigational denials

If we deny Services because they are Experimental Services or Investigational Services, we will send you our written explanation within three days after we received your request. We will explain why we denied the Services and provide additional dispute resolution options. Also, we will provide information about your right to request Independent Medical Review if we had the following information when we made our decision:

- Your treating physician provided us a written statement that you have a Life-Threatening or Seriously Debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we cover than the therapy being requested
- If your treating physician is a Plan Physician, they recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying their recommendation
- You (or your Non–Plan Physician who is a licensed, and either a board-certified or board-eligible, physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician's certification included a statement of the evidence relied upon by the physician in certifying their recommendation. We do not cover the Services of the Non–Plan Provider

Note: You can request IMR for experimental or investigational denials at any time without first filing a grievance with us.

Office of Civil Rights Complaints

If you believe that you have been discriminated against by a Plan Provider or by us because of your race, color, national origin, disability, age, sex (including sex stereotyping and gender identity), or religion, you may file a complaint with the Office of Civil Rights in the United States Department of Health and Human Services ("OCR").

You may file your complaint with the OCR within 180 days of when you believe the act of discrimination occurred. However, the OCR may accept your request after six months if they determine that circumstances prevented timely submission. For more information on the OCR and how to file a complaint with the OCR, see the Notice of Nondiscrimination provided with this *EOC*.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at **1-866-444-EBSA** (**1-866-444-3272**)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Binding Arbitration

For all claims subject to this "Binding Arbitration" section, both Claimants and Respondents give up the right to a jury or court trial and accept the use of binding arbitration. Insofar as this "Binding Arbitration" section applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this *EOC*. Such

retroactive application shall be binding only on the Kaiser Permanente Parties.

Scope of arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *EOC* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. ("Health Plan"), including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of the legal theories upon which the claim is asserted
- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- Governing law does not prevent the use of binding arbitration to resolve the claim

Members enrolled under this *EOC* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeal procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

As referred to in this "Binding Arbitration" section, "Member Parties" include:

- A Member
- A Member's heir, relative, or personal representative
- Any person claiming that a duty to them arises from a Member's relationship to one or more Kaiser Permanente Parties

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any Southern California Permanente Medical Group or The Permanente Medical Group physician
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties
- Any employee or agent of any of the foregoing

"Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts a claim as described above. "Respondent" refers to a Member Party or a Kaiser Permanente Party against whom a claim is asserted.

Rules of Procedure

Arbitrations shall be conducted according to the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of Procedure") developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from Member Services.

Initiating arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and phone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include in the Demand for Arbitration all claims against Respondents that are based on the same incident, transaction, or related circumstances.

Serving Demand for Arbitration

Health Plan, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

Kaiser Foundation Health Plan, Inc.
Legal Department, Professional & Public Liability
393 E. Walnut St.
Pasadena, CA 91188

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

Filing fee

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

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling Member Services.

Number of arbitrators

The number of arbitrators may affect the Claimants' responsibility for paying the neutral arbitrator's fees and expenses (see the Rules of Procedure).

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing after a dispute has arisen and a request for binding arbitration has been submitted that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of arbitrators' fees and expenses

Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the Rules of Procedure. In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs

Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this "Binding Arbitration" section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

General provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondent served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for non-economic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration" section. In accord with the rule that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration" section shall not be denied, stayed, or otherwise impeded because a dispute between a Member Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with another party that arises out of

the same or related transactions and presents a possibility of conflicting rulings or findings.

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2027, your last minute of coverage was at 11:59 p.m. on December 31, 2026). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *EOC* after your membership terminates, except as provided under "Payments after Termination" in this "Termination of Membership" section.

Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, your Group will notify you of the date that your membership will end. Your membership termination date is the first day you are not covered. For example, if your termination date is January 1, 2027, your last minute of coverage was at 11:59 p.m. on December 31, 2026.

Termination of *Agreement*

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. Your Group is required to notify Subscribers in writing if its *Agreement* with us terminates.

Termination for Cause

If you intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider, we may terminate your membership by sending written notice to the Subscriber; termination will be effective 30 days from the date we send the notice. Some examples of fraud include:

- Misrepresenting eligibility information about you or a Dependent
- Presenting an invalid prescription or physician order
- Misusing a Kaiser Permanente ID card (or letting someone else use it)
- Giving us incorrect or incomplete material information. For example, you have entered into a Surrogacy Arrangement and you fail to send us the information we require under "Surrogacy Arrangements" under "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section
- Failing to notify us of changes in family status or Medicare coverage that may affect your eligibility or benefits

If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future. We may also report criminal fraud and other illegal acts to the authorities for prosecution.

Termination of a Product or all Products

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's *Agreement* by sending you written notice at least 180 days before the *Agreement* terminates.

Payments after Termination

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

- Refund any amounts we owe your Group for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Dispute Resolution" section

We will deduct any amounts you owe Health Plan or Plan Providers from any payment we make to you.

State Review of Membership Termination

If you believe that we have terminated your membership because of your ill health or your need for care, you may request a review of the termination by the California Department of Managed Health Care (please see "Department of Managed Health Care Complaints" in the "Dispute Resolution" section).

Continuation of Membership

If your membership under this *EOC* ends, you may be eligible to continue Health Plan membership without a break in coverage. You may be able to continue Group coverage under this *EOC* as described under "Continuation of Group Coverage." Also, you may be able to continue membership under an individual plan as described under "Continuation of Coverage under an Individual Plan." If at any time you become entitled to continuation of Group coverage, please examine your coverage options carefully before declining this coverage. Individual plan premiums and coverage will be different from the premiums and coverage under your Group plan.

Continuation of Group Coverage

COBRA

You may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal Consolidated Omnibus Budget Reconciliation Act ("COBRA"). COBRA applies to most employees (and most of their covered family Dependents) of most employers with 20 or more employees.

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Group for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and Premiums may change, and where to send your Premium payments.

If you enroll in COBRA and exhaust the time limit for COBRA coverage, you may be able to continue Group coverage under state law as described under "Cal-COBRA" in this "Continuation of Group Coverage" section.

Cal-COBRA

If you are eligible for coverage under the California Continuation Benefits Replacement Act ("Cal-COBRA"), you can continue coverage as described in this "Cal-COBRA" section if you apply for coverage in compliance with Cal-COBRA law and pay applicable Premiums.

Eligibility and effective date of coverage for Cal-COBRA after COBRA

If your group is subject to COBRA and your COBRA coverage ends, you may be able to continue Group coverage effective the date your COBRA coverage ends if all of the following are true:

- Your effective date of COBRA coverage was on or after January 1, 2003
- You have exhausted the time limit for COBRA coverage and that time limit was 18 or 29 months
- You do not have Medicare

You must request an enrollment application by calling Member Services within 60 days of the date of when your COBRA coverage ends.

Cal-COBRA enrollment and Premiums

Within 10 days of your request for an enrollment application, we will send you our application, which will include Premium and billing information. You must return your completed application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay Full Premiums within 45 days after the date we issue the bill. The first Premium payment will include coverage from your Cal-COBRA effective date through our current billing cycle. You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

After that first payment, your Premium payment for the upcoming coverage month is due on the last day of the preceding month. The Premiums will not exceed 110 percent of the applicable Premiums charged to a similarly situated individual under the Group benefit plan except that Premiums for disabled individuals after 18 months of COBRA coverage will not exceed 150 percent instead of 110 percent. Returned checks or insufficient funds on electronic payments may be subject to a fee.

If you have selected Ancillary Coverage provided under any other program, the Premium for that Ancillary Coverage will be billed together with required Premiums for coverage under this *EOC*. Full Premiums will then also include Premium for Ancillary Coverage. This means if you do not pay the Full Premiums owed by the due date, we may terminate your membership under this *EOC* and any Ancillary Coverage, as described in the "Termination for nonpayment of Cal-COBRA Premiums" section.

Changes to Cal-COBRA coverage and Premiums

Your Cal-COBRA coverage is the same as for any similarly situated individual under your Group's *Agreement*, and your Cal-COBRA coverage and

Premiums will change at the same time that coverage or Premiums change in your Group's *Agreement*. Your Group's coverage and Premiums will change on the renewal date of its *Agreement* (January 1), and may also change at other times if your Group's *Agreement* is amended. Your monthly invoice will reflect the current Premiums that are due for Cal-COBRA coverage, including any changes. For example, if your Group makes a change that affects Premiums retroactively, the amount we bill you will be adjusted to reflect the retroactive adjustment in Premiums. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended. You can also request one from Member Services.

Cal-COBRA open enrollment or termination of another health plan

If you previously elected Cal-COBRA coverage through another health plan available through your Group, you may be eligible to enroll in Kaiser Permanente during your Group's annual open enrollment period, or if your Group terminates its agreement with the health plan you are enrolled in. You will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA. Please ask your Group for information about health plans available to you either at open enrollment or if your Group terminates a health plan's agreement.

In order for you to switch from another health plan and continue your Cal-COBRA coverage with us, we must receive your enrollment application during your Group's open enrollment period, or within 63 days of receiving the Group's termination notice described under "Group responsibilities." To request an application, please call Member Services. We will send you our enrollment application and you must return your completed application before open enrollment ends or within 63 days of receiving the termination notice described under "Group responsibilities." If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay the bill within 45 days after the date we issue the bill. You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

How you may terminate your Cal-COBRA coverage

You may terminate your Cal-COBRA coverage by sending written notice, signed by the Subscriber, to the address below. Your membership will terminate at 11:59 p.m. on the last day of the month in which we receive your notice. Also, you must include with your notice all amounts payable related to your Cal-COBRA coverage, including Premiums, for the period prior to your termination date.

Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 23127
San Diego, CA 92193-3127

Termination for nonpayment of Cal-COBRA Premiums

If you do not pay Full Premiums by the due date, we may terminate your membership as described in this "Termination for nonpayment of Cal-COBRA Premiums" section. If you intend to terminate your membership, be sure to notify us as described under "How you may terminate your Cal-COBRA coverage" in this "Cal-COBRA" section, as you will be responsible for any Premiums billed to you unless you let us know before the first of the coverage month that you want us to terminate your coverage.

Your Premium payment for the upcoming coverage month is due on the last day of the preceding month. If we do not receive Full Premium payment by the due date, we will send a notice of nonreceipt of payment to the Subscriber's address of record. You will have a 30-day grace period to pay the required Premiums before we terminate your Cal-COBRA coverage for nonpayment. The notice will state when the grace period begins and when the memberships of the Subscriber and all Dependents will terminate if the required Premiums are not paid. Your coverage will continue during this grace period. If we do not receive Full Premium payment by the end of the grace period, we will mail a termination notice to the Subscriber's address of record. After termination of your membership for nonpayment of Cal-COBRA Premiums, you are still responsible for paying all amounts due, including Premiums for the grace period.

Reinstatement of your membership after termination for nonpayment of Cal-COBRA Premiums

If we terminate your membership for nonpayment of Premiums, we will permit reinstatement of your membership three times during any 12-month period if we receive the amounts owed within 15 days of the date of the Termination Notice. We will not reinstate your membership if you do not obtain reinstatement of your terminated membership within the required 15 days, or if we terminate your membership for nonpayment of Premiums more than three times in a 12-month period.

Termination of Cal-COBRA coverage

Cal-COBRA coverage continues only upon payment of applicable monthly Premiums to us at the time we specify, and terminates on the earliest of:

- The date your Group's *Agreement* with us terminates (you may still be eligible for Cal-COBRA through another Group health plan)

- The date you get Medicare
- The date your coverage begins under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have (or that does contain such an exclusion or limitation, but it has been satisfied)
- The date that is 36 months after your original COBRA effective date (under this or any other plan)
- The date your membership is terminated for nonpayment of Premiums as described under "Termination for nonpayment of Cal-COBRA Premiums" in this "Continuation of Membership" section

Note: If the Social Security Administration determined that you were disabled at any time during the first 60 days of COBRA coverage, you must notify your Group within 60 days of receiving the determination from Social Security. Also, if Social Security issues a final determination that you are no longer disabled in the 35th or 36th month of Group continuation coverage, your Cal-COBRA coverage will end the later of: (1) expiration of 36 months after your original COBRA effective date, or (2) the first day of the first month following 31 days after Social Security issued its final determination. You must notify us within 30 days after you receive Social Security's final determination that you are no longer disabled.

Group responsibilities

If your Group's agreement with a health plan is terminated, your Group is required to provide written notice at least 30 days before the termination date to the persons whose Cal-COBRA coverage is terminating. This notice must inform Cal-COBRA beneficiaries that they can continue Cal-COBRA coverage by enrolling in any health benefit plan offered by your Group. It must also include information about benefits, premiums, payment instructions, and enrollment forms (including instructions on how to continue Cal-COBRA coverage under the new health plan). Your Group is required to send this information to the person's last known address, as provided by the prior health plan. Health Plan is not obligated to provide this information to qualified beneficiaries if your Group fails to provide the notice. These persons will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA.

USERRA

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal Uniformed Services Employment and Reemployment Rights Act ("USERRA"). You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group to find out how to elect USERRA coverage and how much you must pay your Group.

Coverage for a Disabling Condition

If you became Totally Disabled while you were a Member under your Group's *Agreement* with us and while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates and is not renewed, we will cover Services for your totally disabling condition until the earliest of the following events occurs:

- 12 months have elapsed since your Group's *Agreement* with us terminated
- You are no longer Totally Disabled
- Your Group's *Agreement* with us is replaced by another group health plan without limitation as to the disabling condition

Your coverage will be subject to the terms of this *EOC,* including Cost Share, but we will not cover Services for any condition other than your totally disabling condition.

For Subscribers and adult Dependents, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months, and makes the person unable to engage in any employment or occupation, even with training, education, and experience.

For Dependent children, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the illness or injury makes the child unable to substantially engage in any of the normal activities of children in good health of like age.

To request continuation of coverage for your disabling condition, you must call Member Services within 30 days after your Group's *Agreement* with us terminates.

Continuation of Coverage under an Individual Plan

If you want to remain a Health Plan member when your Group coverage ends, you might be able to enroll in one of our Kaiser Permanente for Individuals and Families

plans. The premiums and coverage under our individual plan coverage are different from those under this *EOC*.

If you want your individual plan coverage to be effective when your Group coverage ends, you must submit your application within the special enrollment period for enrolling in an individual plan due to loss of other coverage. Otherwise, you will have to wait until the next annual open enrollment period.

To request an application to enroll directly with us, please go to **buykp.org** or call Member Services. For information about plans that are available through Covered California, see "Covered California" below.

Covered California

U.S. citizens or legal residents of the U.S. can buy health care coverage from Covered California. This is California's health benefit exchange ("the Exchange"). You may apply for help to pay for premiums and copayments but only if you buy coverage through Covered California. This financial assistance may be available if you meet certain income guidelines. To learn more about coverage that is available through Covered California, visit **CoveredCA.com** or call Covered California at **1-800-300-1506** (TTY users call **711**).

Miscellaneous Provisions

Administration of *Agreement*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of your Group's *Agreement,* including this *EOC*.

Advance Health Care Directives

The California Health Care Decision Law offers several ways for you to control the kind of health care you will receive if you become very ill or unconscious, including the following:

- A *Power of Attorney for Health Care* lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your own views on life support and other treatments
- *Individual health care instructions* let you express your wishes about receiving life support and other treatment. You can express these wishes to your doctor and have them documented in your medical chart, or you can put them in writing and have that included in your medical chart

For more information about Advance Health Care Directives, refer to our website at **kp.org**, call Member Services, or contact the California Attorney General's Office.

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *EOC*, your Group is required to inform you in accord with applicable law and your Group's *Agreement*.

Applications and Statements

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

Assignment

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

Attorney and Advocate Fees and Expenses

In any dispute between a Member and Health Plan, the Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses.

Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this *EOC* and we have the discretionary authority to review and evaluate claims that arise under this *EOC*. We conduct this evaluation independently by interpreting the provisions of this *EOC*. We may use medical experts to help us review claims. If coverage under this *EOC* is subject to the Employee Retirement Income Security Act ("ERISA") claims procedure regulation (29 CFR 2560.503-1), then we are a "named claims fiduciary" to review claims under this *EOC*.

EOC Binding on Members

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

ERISA Notices

This "ERISA Notices" section applies only if your Group's health benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"). We provide these notices to assist ERISA-covered groups in complying with ERISA. Coverage for Services described in these notices is subject to all provisions of this *EOC*.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the birthing person or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the birthing person's or newborn's attending provider, after consulting with the birthing person, from discharging the birthing person or their newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same Cost Share applicable to other medical and surgical benefits provided under this plan.

Governing Law

Except as preempted by federal law, this *EOC* will be governed in accord with California law and any provision that is required to be in this *EOC* by state or federal law shall bind Members and Health Plan whether or not set forth in this *EOC*.

Group and Members Not Our Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

Member Rights and Responsibilities

As a Member, you have a right to:

- Receive information about your rights and responsibilities.
- Receive information about your health plan, the services your health plan offers you, and the Health Care Providers available to care for you.
- Make recommendations regarding the health plan's member rights and responsibilities policy.
- Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the health plan may impose certain limitations on those services.
- Know the costs for your care, and whether your deductible or out-of-pocket maximum have been met.
- Choose a Health Care Provider in your health plan's network, and change to another doctor in your health plan's network if you are not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a Health Care Provider in your health plan's network, including one with a specialist.
- Have an appointment with a Health Care Provider outside of your health plan's network when your health plan cannot provide timely access to care with an in-network Health Care Provider.
- Certain accommodations for your disability, including:
  - ♦ equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.
  - ♦ full and equal access, as other members of the public, to medical facilities.
  - ♦ extra time for visits if you need it.
  - ♦ taking your service animal into exam rooms with you.

- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
  - Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.
  - to be addressed by your preferred name and pronoun.
- Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
- Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.
- A discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Receive health care coverage even if you have a pre-existing condition.
- Receive Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
- Receive certain preventive health services, including many without a co-pay, co-insurance, or deductible.
- Have no annual or lifetime dollar limits on basic health care services.
- Keep eligible dependent(s) on your health plan. Ask your Group whether Dependents are eligible to enroll under your plan.
- Protection from illegal balance billing by a Health Care Provider.
- Request from your health plan a second opinion by an Appropriately Qualified Health Care Professional.
- Expect your health plan to keep your personal health information private by following its privacy policies, and state and federal laws.
- Ask most Health Care Providers for information regarding who has received your personal health information.
- Ask your health plan or your doctor to contact you only in certain ways or at certain locations.
- Have your medical information related to sensitive services protected.
- Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
- Have an interpreter who speaks your language at all points of contact when you receive health care services.
- Have an interpreter provided at no cost to you.
- Receive written materials in your preferred language where required by law.
- Have health information provided in a usable format if you are blind, deaf, or have low vision.
- Request continuity of care if your Health Care Provider or medical group leaves your health plan or you are a new health plan member.
- Have an Advance Health Care Directive.
- Be fully informed about your health plan's grievances procedure and understand how to use it without fear of interruption to your health care.
- File a complaint, grievance, or appeal in your preferred language about:
  - your health plan or Health Care Provider.
  - any care you receive, or access to care you seek.
  - any covered service or benefit decision that your health plan makes.
  - any improper charges or bills for care.
  - any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
  - not meeting your language needs.
- Know why your health plan denies a service or treatment.
- Contact the Department of Managed Health Care if you are having difficulty accessing health care services or have questions about your health plan.
- To ask for an Independent Medical Review if your health plan denied, modified, or delayed a health care service.

As a Member, you have the responsibility to:

- Treat all Health Care Providers, Health Care Provider staff, and health plan staff with respect and dignity.
- Share the information needed with your health plan and Health Care Providers, to the extent possible, to help you get appropriate care.
- Participate in developing mutually agreed-upon treatment goals with your Health Care Providers and follow the treatment plans and instructions to the degree possible.
- To the extent possible, keep all scheduled appointments, and call your Health Care Provider if you may be late or need to cancel.
- Refrain from submitting false, fraudulent, or misleading claims or information to your health plan or Health Care Providers.
- Notify your health plan if you have any changes to your name, address, or family members covered under your health plan.
- Timely pay any premiums, copayments, and charges for non-covered services.
- Notify your health plan as soon as reasonably possible if you are billed inappropriately.

No Waiver

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

Notices Regarding Your Coverage

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call Member Services as soon as possible to give us their new address. If a Member does not reside with the Subscriber, or needs to have confidential information sent to an address other than the Subscriber's address, they should call Member Services to discuss alternate delivery options.

Note: When we tell your Group about changes to this *EOC* or provide your Group other information that affects you, your Group is required to notify the Subscriber within 30 days (or five days if we terminate your Group's *Agreement*) after receiving the information from us. The Subscriber is also responsible for notifying Group of any change in contact information.

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.

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information. We also require contracting providers to protect your protected health information. Your protected health information is individually-identifiable information (oral, written, or electronic) about your health, health care services you receive, or payment for your health care. You may generally see and receive copies of your protected health information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your protected health information.

You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means. You may request confidential communication by completing a confidential communication request form, which is available on **kp.org** under "Request for confidential communications forms." Your request for confidential communication will be valid until you submit a revocation or a new request for confidential communication. If you have questions, please call Member Services.

We may use or disclose your protected health information for treatment, health research, payment, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give protected health information to others, such as government agencies or in judicial actions. In addition, protected health information is shared with your Group only with your authorization or as otherwise permitted by law.

We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. OUR *NOTICE OF PRIVACY PRACTICES*, WHICH PROVIDES ADDITIONAL INFORMATION ABOUT OUR PRIVACY PRACTICES AND YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION, IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. To request a copy, please call Member Services. You can also find the notice at a Plan Facility or on our website at **kp.org**.

Public Policy Participation

The Kaiser Foundation Health Plan, Inc., Board of Directors establishes public policy for Health Plan. A list of the Board of Directors is available on our website at **about.kp.org** or from Member Services. If you would like to provide input about Health Plan public policy for consideration by the Board, please send written comments to:

Kaiser Foundation Health Plan, Inc.
Office of Board and Corporate Governance Services
One Kaiser Plaza, 19th Floor
Oakland, CA 94612

Helpful Information

How to Obtain this *EOC* in Other Formats

You can request a copy of this *EOC* in an alternate format (Braille, audio, electronic text file, or large print) by calling Member Services.

Provider Directory

Refer to the Provider Directory for your Service Area for the following information:

- A list of Plan Physicians
- The location of Plan Facilities and the types of covered Services that are available from each facility
- Hours of operation
- Appointments and advice phone numbers

This directory is available on our website at **kp.org**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call Member Services.

Online Tools and Resources

Here are some tools and resources available on our website at **kp.org**:

- How to use our Services and make appointments
- Tools you can use to email your doctor's office, view test results, refill prescriptions, and schedule routine appointments
- Health education resources
- Preventive care guidelines
- Member rights and responsibilities

You can also access tools and resources using the KP app on your smartphone or other mobile device.

Document Delivery Preferences

Many Health Plan documents are available electronically, such as bills, statements, and notices. If you prefer to get documents in electronic format, go to **kp.org** or call Member Services. You can change delivery preference at any time. To get a copy of a specific Heath Plan document in printed format, call Member Services.

How to Reach Us

Appointments

If you need to make an appointment, please call us or visit our website:

Call The appointment phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call Member Services)

Website **kp.org** for routine (non-urgent) appointments with your personal Plan Physician or another Primary Care Physician

Not sure what kind of care you need?

If you need advice on whether to get medical care, or how and when to get care, we have licensed health care professionals available to assist you by phone 24 hours a day, seven days a week:

Call The appointment or advice phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call Member Services)

Member Services

If you have questions or concerns about your coverage, how to obtain Services, or the facilities where you can receive care, you can reach us in the following ways:

Call **1-800-464-4000** (English and more than 150 languages using interpreter services)
1-800-788-0616 (Spanish)
1-800-757-7585 (Chinese dialects)
TTY users call **711**

24 hours a day, seven days a week (closed holidays)

Visit Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)

Write Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)

Website kp.org

Estimates, bills, and statements

For the following concerns, please call us at the number below:

- If you have questions about a bill
- To find out how much you have paid toward your Plan Deductible (if applicable) or Plan Out-of-Pocket Maximum
- To get an estimate of Charges for Services that are subject to the Plan Deductible (if applicable)

Call **1-800-464-4000** (TTY users call **711**)

24 hours a day, seven days a week (closed holidays)

Website kp.org

Away from Home Travel Line

If you have questions about your coverage when you are away from home:

Call **1-951-268-3900**

24 hours a day, seven days a week (closed holidays)

Website kp.org/travel

Authorization for Post-Stabilization Care

To request prior authorization for Post-Stabilization Care as described under "Emergency Services" in the "How to Obtain Services" section:

Call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card (TTY users call **711**)

24 hours a day, seven days a week

Help with claim forms for Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, COVID-19 Services, Plan Doula services, and human milk

If you need a claim form to request payment or reimbursement for Services described under "Emergency Services and Urgent Care" or "Ambulance Services" in the "Benefits" section, or COVID-19 Services under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Pharmacy Services," and "Preventive Services" in the "Benefits" section, or if you need help completing the form, you can reach us by calling or by visiting our website.

Call **1-800-464-4000** (TTY users call **711**)

24 hours a day, seven days a week (closed holidays)

Website kp.org

Submitting claims for Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, COVID-19 Services, Plan Doula services, and human milk

If you need to submit a completed claim form for Services described under "Emergency Services and Urgent Care" or "Ambulance Services" in the "Benefits" section, or COVID-19 Services under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Pharmacy Services," and "Preventive Services" in the "Benefits" section, or if you need to submit other information that we request about your claim, send it to our Claims Department:

Write Kaiser Permanente
Claims Administration - SCAL
P.O. Box 7004
Downey, CA 90242-7004

Text telephone access ("TTY")

If you use a text telephone device ("TTY," also known as "TDD") to communicate by phone, you can use the California Relay Service by calling **711**.

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. For more information on the interpreter services we offer, please call Member Services.

Payment Responsibility

This "Payment Responsibility" section briefly explains who is responsible for payments related to the health care coverage described in this *EOC*. Payment responsibility is more fully described in other sections of the *EOC* as described below:

- Your Group is responsible for paying Premiums, except that you are responsible for paying Premiums if you have COBRA or Cal-COBRA (refer to "Premiums" in the "Premiums, Eligibility, and Enrollment" section and "COBRA" and "Cal-COBRA" under "Continuation of Group Coverage" in the "Continuation of Membership" section)
- Your Group may require you to contribute to Premiums (your Group will tell you the amount and how to pay)
- You are responsible for paying your Cost Share for covered Services (refer to the "Cost Share Summary" section)
- If you receive Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, or COVID-19 Services from a Non–Plan Provider, or if you receive emergency ambulance Services, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us (refer to "Emergency Services and Urgent Care" in the "Benefits" section)
- If you receive Services from Non–Plan Providers that we did not authorize (other than Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 Services) and you want us to pay for the care, you must submit a grievance (refer to "Grievances" in the "Dispute Resolution" section)
- If you have coverage with another plan or with Medicare, we will coordinate benefits with the other coverage (refer to "Coordination of Benefits" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- In some situations, you or another party may be responsible for reimbursing us for covered Services (refer to "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- You must pay the full price for noncovered Services

Important Notices

Notice of Language Assistance

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

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

Arabic: تنبيه. المساعدة اللغوية متوفرة بدون تكلفة عليك. يمكنك طلب خدمات الترجمة، بما في ذلك مترجمي لغة الإشارة. يمكنك طلب وثائق مترجمة بلغتك أو بصيغ بديلة مثل طريقة برايل للمكفوفين أو ملف صوتي أو الطباعة بأحرف كبيرة. يمكنك أيضًا طلب وسائل مساعدة وأجهزة مساعدة في مرافقنا. اتصل مع قسم خدمات الأعضاء لدينا للحصول على المساعدة. لا تعمل خدمات الأعضاء في العطلات الرئيسية.

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

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

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

Chinese：请注意，我们有免费语言协助。您可以要求我们提供口译服务，包括手语翻译员。您可以要求将资料翻译成您所使用的语言或其他格式的版本，如盲文、音频或大字版。您还可以要求使用我们设施中的语言辅助工具和设备。请联系会员服务部以获取帮助。重要节假日期间会员服务不开放。

- Medicare，包括 D-SNP：**1-800-443-0815** (TTY **711**)，每周 7 天，上午 8 点至晚上 8 点
- Medi-Cal：**1-855-839-7613** (TTY 711)，每周 7 天，每天 24 小时
- 所有其他保险计划：**1-800-757-7585** (TTY **711**)，每周 7 天，每天 24 小时

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

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

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

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

Hmong: FAJ SEEB. Muaj kev pab txhais lus pub dawb rau koj. Koj muaj peev xwm thov kom pab txhais lus, suav nrog kws txhais lus piav tes. Koj muaj peev xwm thov kom muab cov ntaub ntawv no txhais ua koj yam lus los sis ua lwm hom, xws li hom ntawv rau neeg dig muag xuas, tso ua suab lus, los sis luam tawm kom koj. Koj kuj tuaj yeem thov kom muab tej khoom pab dawb thiab tej khoom siv txhawb tau rau ntawm peb cov chaw kuaj mob. Hu mus thov kev pab

rau ntawm peb Lub Chaw Pab Tswv Cuab. Lub chaw pab tswv cuab kaw rau cov hnub so uas tseem ceeb.

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

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

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

Khmer (Cambodian): យកចិត្តទុកដាក់។ ជំនួយភាសាគឺមានដោយមិនគិតថ្លៃសម្រាប់អ្នក។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ រួមទាំងអ្នកបកប្រែភាសាសញ្ញាផងដែរ។ អ្នកអាចស្នើសុំឯកសារដែលត្រូវបានបកប្រែជាភាសារបស់អ្នក ឬទម្រង់ផ្សេងទៀតដូចជាអក្សរស្ដាប សំឡេង ឬអក្សរធំៗ។ អ្នកក៏អាចស្នើសុំជំនួយបន្ថែម និងឧបករណ៍ជំនួយនៅតាមកន្លែងរបស់យើងផងដែរ។ សូមទូរសព្ទទៅផ្នែកសេវាសមាជិករបស់យើងសម្រាប់ជំនួយ។ សេវាសមាជិកត្រូវបានបិទនៅថ្ងៃឈប់សម្រាកសំខាន់ៗ។

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

Korean: 안내 사항. 무료 언어 지원 제공. 수화 통역사를 포함한 통역 서비스를 요청할 수 있습니다. 한국어로 번역된 자료 또는 점자, 오디오 또는 큰 글씨와 같은 대체 형식의 자료를 요청할 수 있습니다. 저희 시설에서 보조 기구와 장치를 요청할 수도 있습니다. 가입자 서비스 부서에 도움을 요청하시기 바랍니다. 주요 공휴일에는 가입자 서비스를 운영하지 않습니다.

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

Laotian: ໂປດຊາບ. ມີການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ທ່ານສ າມາດຂໍບໍລິການນາຍພາສາ, ລວມທັງນາຍພາສາມື. ທ່ານ ສາມາດຂໍໃຫ້ແປເອກະສານນີ້ເປັນພາສາຂອງທ່ານ ຫຼື ຮູບ ແບບອື່ນ ເຊັ່ນ ອັກສອນນູນ, ສຽງ, ຫຼື ການພິມຂະໜາດໃ ຫຍ່. ນອກຈາກນັ້ນທ່ານຍັງສາມາດຮ້ອງຂໍເຄື່ອງຊ່ວຍຟັງ ແລະ ອຸປະກອນການຊ່ວຍເຫຼືອໃນສະຖານທີ່ຂອງພວກ ເຮົາ. ໂທຫາພະແນກບໍລິການສະມາຊິກຂອງພວກເຮົາເ ພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. ພະແນກບໍລິການສະມາຊິກແ ມ່ນປິດໃນວັນພັກທີ່ສໍາຄັນຕ່າງໆ.

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

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

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

Navajo: GIHA. Tséé' naalkáah sidá'ígíí éí doo tł'éé' íił'į' dah sidáa'ígíí. Tł'éé'góó tł'ízí'ígíí éí tséé' naalkáah sidá'ígíí bikáa' dah sidaaígíí, t'á'ii bik'eh dah na'ałkaígíí. T'á'ii éí tł'éé'góó tł'ízí'ígíí bik'eh dah deidiyós, t'á'ii éí bi'éé' bik'eh dah na'ałkaígíí bik'eh dah deidiyós. T'á'ii bik'eh dah na'ałkaígíí bikáa' dah na'ałkaígíí t'áá ałtso bik'eh dah deidiyós. Bi'éé' naalkáah sidá'ígíí bik'eh ha'a'aah. T'á'ii bik'eh dah na'ałkaígíí éí bik'eh dah naazhjaa'ígíí bik'eh dah na'ałkaígíí.

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

Punjabi: ਧਿਆਨ ਦਿਓ। ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ਿਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਿੱਤੇ ਜਾਣ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ, ਜਿਸ ਵਿੱਚ ਸਾਈਨ ਲੈਂਗੁਵੇਜ਼ ਦੇ ਦੁਭਾਸ਼ਿਏ ਵੀ ਸ਼ਾਮਲ ਹਨ। ਤੁਸੀਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ, ਜਾਂ ਕਿਸੇ ਵੈਕਲਪਿਕ ਫਾਰਮੈਟ ਵਿੱਚ ਅਨੁਵਾਦਿਤ ਕਰਨ ਲਈ ਵੀ ਕਹਿ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸਹੂਲਤਾਂ 'ਤੇ ਸਹਾਇਕ ਏਡਜ਼ ਅਤੇ ਉਪਕਰਨਾਂ ਲਈ ਵੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ ਸਾਡੇ ਮੈਂਬਰਾਂ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦੇ ਵਿਭਾਗ ਨੂੰ ਕਾੱਲ ਕਰੋ। ਮੈਂਬਰਾਂ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਾ ਵਿਭਾਗ ਮੁੱਖ ਛੁਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ।

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

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

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

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

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

Tagalog: PAUNAWA. May magagamit na tulong sa wika nang wala kang babayaran. Maaari kang humiling ng mga serbisyo ng interpreter, kasama ang mga interpreter sa sign language. Maaari kang humiling ng mga babasahin na nakasalin-wika sa iyong wika o sa mga alternatibong format, na tulad ng braille, audio, o malalaking titik. Puwede ka ring humiling ng mga karagdagang tulong at device sa aming mga pasilidad. Tawagan ang aming departamento ng Mga Serbisyo sa Miyembro para sa tulong. Ang mga serbisyo sa miyembro ay sarado sa mga pangunahing holiday.

- Medicare, kasama ang D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. hanggang 8 p.m., 7 araw sa isang linggo
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo
- Ang lahat ng iba: **1-800-464-4000** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo

Thai: ส่งถึง มีบริการให้ความช่วยเหลือด้านภาษา แก่ท่านโดยไม่มีค่าใช้จ่าย ท่านสามารถขอรับบริการล่าม รวมถึงล่ามภาษามือได้ ท่านสามารถขอให้แปลเอกสารเป็นภาษาของท่าน หรือในรูปแบบอื่นๆ เช่นอักษรเบรลล์ ไฟล์เสียง หรือตัวอักษรขนาดใหญ่ ท่านสามารถขอรับอุปกรณ์ ช่วยเหลือและอุปกรณ์เสริมได้ ณ สถานที่ให้บริการของเรา โทรติดต่อฝ่ายบริการสมาชิกของเราเพื่อขอความช่วยเหลือได้ ฝ่ายบริการสมาชิกจะปิดทำการในวันหยุดราชการต่างๆ

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

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

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

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

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

Nondiscrimination Notice

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

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

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

Kaiser Permanente provides the following services:

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

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

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

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

How to file a grievance with Kaiser Permanente

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

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

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

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

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

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

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

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

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

  California Department of Health Care Services Office of Civil Rights Complaint forms are available at: http://www.dhcs.ca.gov/Pages/Language_Access.aspx
- **Online:** Send an email to CivilRights@dhcs.ca.gov

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

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

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
  U.S. Department of Health and Human Services Office of Civil Rights Complaint forms are available at: https://www.hhs.gov/ocr/office/file/index.html
- **Online:** Visit the **Office of Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Southern California Region

A nonprofit corporation and a Medicare Advantage Organization

EOC #2 - Kaiser Permanente Senior Advantage (HMO) with Part D
Evidence of Coverage for
AFFIRM INC

Group ID: 235801 Contract: 1 Version: 6 *EOC* Number: 2 Issue Date: October 21, 2025

January 1, 2026, through December 31, 2026

Member Services
Seven days a week, 8 a.m.–8 p.m.
1-800-443-0815 (TTY users call **711**)
kp.org

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

*Este documento está disponible de manera gratuita en español. Si desea información adicional, llame al número de nuestro Servicio a los Miembros al **1-800-443-0815**. (Los usuarios de TTY deben llamar al 711). El horario de atención es de 8 a. m. a 8 p. m., los 7 días de la semana.*

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

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

TABLE OF CONTENTS FOR EOC #2

Benefit Highlights 1
Introduction 3
About Kaiser Permanente 3
Term of this *EOC* 3
Definitions 4
Premiums, Eligibility, and Enrollment 9
Premiums 9
Medicare Premiums 10
Who Is Eligible 11
How to Enroll and When Coverage Begins 13
How to Obtain Services 15
Routine Care 15
Urgent Care 15
Our Advice Nurses 15
Your Personal Plan Physician 16
Getting a Referral 16
Travel and Lodging for Certain Services 17
Second Opinions 17
Contracts with Plan Providers 18
Receiving Care Outside of Your Home Region Service Area 19
Your ID Card 19
Getting Assistance 19
Plan Facilities 19
Provider Directory 20
Pharmacy Directory 20
Emergency Services and Urgent Care 20
Emergency Services 20
Urgent Care 21
Payment and Reimbursement 21
Benefits and Your Cost Share 21
Your Cost Share 22
Outpatient Care 25
Hospital Inpatient Services 26
Ambulance Services 27
Bariatric Surgery 28
Dental Services 28
Dialysis Care 29
Durable Medical Equipment (“DME”) for Home Use 30
Fertility Services 31
Fitness benefit (One Pass™) 32
Health Education 32
Hearing Services 33
Home Health Care 33
Hospice Care 34
Mental Health Services 35
Opioid Treatment Program Services 36
Ostomy, Urological, and Specialized Wound Care Supplies 36

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services 37
Outpatient Prescription Drugs, Supplies, and Supplements 37
Preventive Services 48
Prosthetic and Orthotic Devices 49
Reconstructive Surgery 50
Religious Nonmedical Health Care Institution Services 51
Services Associated with Clinical Trials 51
Skilled Nursing Facility Care 52
Substance Use Disorder Treatment 53
Telehealth Visits 53
Transplant Services 54
Vision Services 55
Exclusions, Limitations, Coordination of Benefits, and Reductions 56
Exclusions 56
Limitations 58
Coordination of Benefits 58
Reductions 59
Requests for Payment 61
Asking Us to Pay Our Share of a Bill for Covered Medical Services or Drugs 61
How to Ask Us to Pay You Back or Pay a Bill You Got 62
We'll Consider Your Request for Payment and Say *Yes* or *No* 63
Your Rights and Responsibilities 63
Our plan must honor your rights and cultural sensitivities 63
Your responsibilities as a Member of our plan 67
Coverage Decisions, Appeals, and Complaints 67
What to Do if You Have a Problem or Concern 67
Where To Get More Information and Personalized Help 68
Which Process to Use for Your Problem 68
A Guide to Coverage Decisions and Appeals 68
Medical Care: How to Ask for a Coverage Decision or Make an Appeal 70
Part D Drugs: How to Ask for a Coverage Decision or Make an Appeal 74
How to Ask Us to Cover a Longer Inpatient Hospital Stay if You Think You're Being Discharged Too Soon 79
How to Ask Us to Keep Covering Certain Medical Services if You Think Your Coverage Is Ending Too Soon 82
Taking Your Appeal to Levels 3, 4, and 5 83
How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns 85
You can also tell Medicare about your complaint 86
Additional Review 86
Binding Arbitration 87
Termination of Membership 89
Termination Due to Loss of Eligibility 89
Termination of *Agreement* 89
Disenrolling from Senior Advantage 89
Termination of Contract with the Centers for Medicare & Medicaid Services 90
Termination for Cause 90
Termination for Nonpayment of Premiums 91
Termination of a Product or all Products 91
Payments after Termination 91
Review of Membership Termination 91
Continuation of Membership 91
Continuation of Group Coverage 91
Conversion from Group Membership to an Individual Plan 92

Miscellaneous Provisions 92
Administration of Agreement 92
Amendment of *Agreement* 92
Applications and Statements 92
Assignment 92
Attorney and Advocate Fees and Expenses 92
Claims Review Authority 92
EOC Binding on Members 93
ERISA Notices 93
Governing Law 93
Group and Members Not Our Agents 93
No Waiver 93
Notices Regarding Your Coverage 93
Notice about Medicare Secondary Payer Subrogation Rights 93
Overpayment Recovery 93
Public Policy Participation 94
Telephone Access (TTY) 94
Phone Numbers and Resources 94
Kaiser Permanente Senior Advantage contacts 94
Get help from Medicare 96
State Health Insurance Assistance Program (SHIP) 96
Quality Improvement Organization (QIO) 97
Social Security 97
Medicaid 97
Railroad Retirement Board (RRB) 98
Group Insurance or Other Health Insurance from an Employer 98

Benefit Highlights

Accumulation Period

The Accumulation Period for this plan is 1/1/26 through 12/31/26 (calendar year).

Plan Out-of-Pocket Maximum

For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to the following amount:

For any one Member.....$1,000 per calendar year

Plan Deductible	None

Plan Provider Office Visits	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$20 per visit
Most Physician Specialist Visits	$20 per visit
Annual Wellness visit and the "Welcome to Medicare" preventive visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	$20 per visit
Urgent care consultations, evaluations, and treatment	$20 per visit
Physical, occupational, and speech therapy	$20 per visit

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

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$50 per procedure
Allergy injections (including allergy serum)	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	$20 per visit

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$500 per admission

Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share).

Ambulance and Transportation Services	**You Pay**
Ambulance Services	$100 per trip

Prescription Drug Coverage	**You Pay**
This plan covers Medicare Part D prescription drugs in accord with our Part D formulary.	
Initial Coverage Stage—until you have spent $2,100 in 2026. (If you spend $2,100, you move on to the Catastrophic Coverage Stage):	
Generic drugs	$10 for up to a 100-day supply
Brand-name drugs	$35 for up to a 100-day supply
Catastrophic Coverage Stage	No charge

Durable Medical Equipment (DME)	You Pay
Covered durable medical equipment for home use as described in this *EOC*	20 percent Coinsurance

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	$500 per admission
Individual outpatient mental health evaluation and treatment	$20 per visit
Group outpatient mental health treatment	$10 per visit

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	$500 per admission
Individual outpatient substance use disorder evaluation and treatment	$20 per visit
Group outpatient substance use disorder treatment	$5 per visit

Home Health Services	You Pay
Home health care (part-time, intermittent)	No charge

Other	You Pay
Eyeglasses or contact lenses every 24 months	Amount in excess of $150 Allowance
Skilled Nursing Facility care (up to 100 days per benefit period)	No charge
External prosthetic and orthotic devices as described in this *EOC*	20 percent Coinsurance
Ostomy, urological, and specialized wound care supplies	20 percent Coinsurance
Fitness benefit – One Pass™ (includes access to in-network gyms and one home fitness kit per calendar year)	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, refer to the “Benefits and Your Cost Share” and “Exclusions, Limitations, Coordination of Benefits, and Reductions” sections.

Introduction

Kaiser Foundation Health Plan, Inc. (Health Plan) has a contract with the Centers for Medicare & Medicaid Services as a Medicare Advantage Organization.

This contract provides Medicare Services (including Medicare Part D prescription drug coverage) through "Kaiser Permanente Senior Advantage (HMO) with Part D" (Senior Advantage), except for hospice care for Members with Medicare Part A, which is covered under Original Medicare. Enrollment in this Senior Advantage plan means that you are automatically enrolled in Medicare Part D. Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

This *Evidence of Coverage* ("*EOC*") describes our Senior Advantage health care coverage provided under the *Group Agreement (Agreement)* between Kaiser Foundation Health Plan, Inc. ("Health Plan") and your Group (the entity with which Health Plan has entered into the *Agreement*).

The *Agreement* contains additional terms such as Premiums, when coverage can change, the effective date of coverage, and the effective date of termination. The *Agreement* must be consulted to determine the exact terms of coverage. A copy of the *Agreement* is available from your Group.

For benefits provided under any other program, refer to that other plan's evidence of coverage. For benefits provided under any other program offered by your Group (for example, workers compensation benefits), refer to your Group's materials.

In this *EOC*, Health Plan is sometimes referred to as "we" or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *EOC*; please see the "Definitions" section for terms you should know.

It is important to familiarize yourself with your coverage by reading this *EOC* completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

About Kaiser Permanente

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY GET HEALTH CARE.

Kaiser Permanente provides Services directly to our Members through an integrated medical care program. Health Plan, Plan Hospitals, and the Medical Group work together to provide our Members with quality care. Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital Services, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *EOC*. Plus, our health education programs offer you great ways to protect and improve your health.

We provide covered Services to Members using Plan Providers located in our Service Area, which is described in the "Definitions" section. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Covered Services received outside of your Home Region Service Area as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Your Cost Share" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Your Cost Share" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section
- Routine Services associated with Medicare-approved clinical trials as described under "Services Associated with Clinical Trials" in the "Benefits and Your Cost Share" section

Term of this *EOC*

This *EOC* is for the period January 1, 2026, through December 31, 2026, unless amended. Benefits, Copayments, and Coinsurance may change on January 1 of each year and at other times in accord with your Group's *Agreement* with us. Your Group can tell you

whether this *EOC* is still in effect and give you a current one if this *EOC* has been amended.

Definitions

Some terms have special meaning in this *EOC*. When we use a term with special meaning in only one section of this *EOC*, we define it in that section. The terms in this "Definitions" section have special meaning when capitalized and used in any section of this *EOC*.

Accumulation Period: A period of time no greater than 12 consecutive months for purposes of accumulating amounts toward any deductibles (if applicable) and out-of-pocket maximums. The Accumulation Period for this *EOC* is from 1/1/26 through 12/31/26.

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

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

Centers for Medicare & Medicaid Services (CMS): The federal agency that administers the Medicare program.

Ancillary Coverage: Optional benefits such as acupuncture, chiropractic, or dental coverage that may be available to Members enrolled under this *EOC.* If your plan includes Ancillary Coverage, this coverage will be described in an amendment to this *EOC* or a separate agreement from the issuer of the coverage.

Charges: "Charges" means the following:

- For Services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members
- For Services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)
- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts your Cost Share from its payment, the amount Kaiser Permanente would have paid if it did not subtract your Cost Share

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service under this *EOC*.

Complaint: The formal name for making a complaint is **filing a grievance**. The complaint process is used only for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

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

Comprehensive Outpatient Rehabilitation Facility (CORF): A facility that mainly provides rehabilitation Services after an illness or injury, including physician's Services, physical therapy, social or psychological Services, and outpatient rehabilitation.

Copayment: A specific dollar amount that you must pay when you receive a covered Service under this *EOC*. Note: The dollar amount of the Copayment can be $0 (no charge).

Cost Share: The amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance. Cost Share also means any Charges you are required to pay for covered Medicare Part D drugs. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible.

Coverage Determination: An initial determination we make about whether a Part D drug prescribed for you is covered under Part D and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription for a Part D drug to a Plan Pharmacy and the pharmacy tells you the prescription isn't covered by us, that isn't a Coverage Determination. You need to call or write us to ask for a formal decision about the coverage. Coverage Determinations are called "coverage decisions" in this *EOC*.

Dependent: A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

Durable Medical Equipment (DME): Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech-generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency Medical Condition: A medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

A mental health condition is an emergency medical condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to themselves or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

Emergency Services: Covered Services that are (1) rendered by a provider qualified to furnish Emergency Services; and (2) needed to treat, evaluate, or Stabilize an Emergency Medical Condition such as:

- A medical screening exam that is within the capability of the Emergency Department of a hospital, including ancillary services (such as imaging and laboratory Services) routinely available to the Emergency Department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post Stabilization Care and not Emergency Services)

***EOC*:** This *Evidence of Coverage* document, including any amendments, which describes the health care coverage of "Kaiser Permanente Senior Advantage (HMO) with Part D" under Health Plan's *Agreement* with your Group.

Extra Help: A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Family: A Subscriber and all of their Dependents.

Grievance: A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Group: The entity with which Health Plan has entered into the *Agreement* that includes this *EOC*.

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. This *EOC* sometimes refers to Health Plan as "we" or "us."

Home Region: The Region where you enrolled (either the Northern California Region or the Southern California Region).

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

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

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

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

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

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

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of

practice that are consistent with a standard of care in the medical community.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Organization: A public or private entity organized and licensed by a state as a risk-bearing entity that has a contract with the Centers for Medicare & Medicaid Services to provide Services covered by Medicare, except for hospice care covered by Original Medicare. Kaiser Foundation Health Plan, Inc., is a Medicare Advantage Organization.

Medicare Advantage Plan: Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be (i) an HMO, (ii) a PPO, (iii) a Private Fee-for-Service (PFFS) plan, or (iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. A person enrolled in a Medicare Part D plan has Medicare Part D by virtue of their enrollment in the Part D plan. This *EOC* is for a Medicare Part D plan.

Medicare Health Plan: A Medicare Health Plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage plans, Medicare Cost plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medigap (Medicare Supplement Insurance) Policy: Medicare supplement insurance sold by private insurance companies to fill *gaps* in the Original Medicare plan coverage. Medigap policies only work with the Original Medicare plan. (A Medicare Advantage Plan is not a Medigap policy.)

Member: A person who is eligible and enrolled under this *EOC*, and for whom we have received applicable Premiums. This *EOC* sometimes refers to a Member as "you."

Non-Physician Specialist Visits: Consultations, evaluations, and treatment by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

Non–Plan Hospital: A hospital other than a Plan Hospital.

Non–Plan Pharmacy: A pharmacy other than a Plan Pharmacy. These pharmacies are also called "out-of-network pharmacies."

Non–Plan Physician: A physician other than a Plan Physician.

Non–Plan Provider: A provider other than a Plan Provider.

Non–Plan Psychiatrist: A psychiatrist who is not a Plan Physician.

Non–Plan Skilled Nursing Facility: A Skilled Nursing Facility other than a Plan Skilled Nursing Facility.

Organization Determination: A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or Services. Organization determinations are called coverage decisions in this *EOC*.

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

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your health resulting from an unforeseen illness or an unforeseen injury if all of the following are true:

- You are temporarily outside our Service Area
- A reasonable person would have believed that your health would seriously deteriorate if you delayed treatment until you returned to our Service Area

Physician Specialist Visits: Consultations, evaluations, and treatment by physician specialists, including personal Plan Physicians who are not Primary Care Physicians.

Plan Deductible: The amount you must pay under this *EOC* in the calendar year for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that calendar year. Refer to the "Benefits and Your Cost Share" section to learn whether your coverage includes a Plan Deductible, the Services that

are subject to the Plan Deductible, and the Plan Deductible amount.

Plan Facility: Any facility listed in the Provider Directory on our website at **kp.org/facilities**. Plan Facilities include Plan Hospitals, Plan Medical Offices, and other facilities that we designate in the directory. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call Member Services.

Plan Hospital: Any hospital listed in the Provider Directory on our website at **kp.org/facilities**. In the directory, some Plan Hospitals are listed as Kaiser Permanente Medical Centers. The directory is updated periodically. The availability of Plan Hospitals may change. If you have questions, please call Member Services.

Plan Medical Office: Any medical office listed in the Provider Directory on our website at **kp.org/facilities**. In the directory, Kaiser Permanente Medical Centers may include Plan Medical Offices. The directory is updated periodically. The availability of Plan Medical Offices may change. If you have questions, please call Member Services.

Plan Optical Sales Office: An optical sales office owned and operated by Kaiser Permanente or another optical sales office that we designate. Refer to the Provider Directory on our website at **kp.org/facilities** for locations of Plan Optical Sales Offices. In the directory, Plan Optical Sales Offices may be called "Vision Essentials." The directory is updated periodically. The availability of Plan Optical Sales Offices may change. If you have questions, please call Member Services.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Out-of-Pocket Maximum: The total amount of Cost Share you must pay under this *EOC* in the calendar year for certain covered Services that you receive in the same calendar year. Refer to the "Benefits and Your Cost Share" section to find your Plan Out-of-Pocket Maximum amount and to learn which Services apply to the Plan Out-of-Pocket Maximum.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Refer to the Provider Directory on our website at **kp.org/facilities** for locations of Plan Pharmacies. The directory is updated periodically. The availability of Plan Pharmacies may change. If you have questions, please call Member Services.

Plan Physician: Any licensed physician who is a partner or employee of the Medical Group, or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that Health Plan designates as a Plan Provider.

Plan Skilled Nursing Facility: A Skilled Nursing Facility approved by Health Plan.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that this condition is clinically stable. You're considered clinically stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards that you're safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Premiums: The periodic amounts for your membership under this *EOC*.

Preventive Services: Covered Services that prevent or detect illness and do one or more of the following:

- Protect against disease and disability or further progression of a disease
- Detect disease in its earliest stages before noticeable symptoms develop

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Refer to the Provider Directory on our website at **kp.org** for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call Member Services.

Primary Care Visits: Evaluations and treatment provided by Primary Care Physicians and primary care Plan Providers who are not physicians (such as nurse practitioners).

Provider Directory: A directory of Plan Physicians and Plan Facilities in your Home Region. This directory is available on our website at **kp.org/directory**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call Member Services.

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

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

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 of each year and are currently the District of Columbia and parts of Northern California, Southern California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For the current list of Region locations, please visit our website at **kp.org** or call Member Services.

Serious Emotional Disturbance of a Child Under Age 18: A condition identified as a "mental disorder" in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:

- As a result of the mental disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
- The child displays psychotic features, or risk of suicide or violence due to a mental disorder
- The child meets special education eligibility requirements under Section 5600.3(a)(2)(C) of the Welfare and Institutions Code

Service Area: The geographic area approved by the Centers for Medicare & Medicaid Services within which an eligible person may enroll in Senior Advantage. Note: Subject to approval by the Centers for Medicare & Medicaid Services, we may reduce or expand our Service Area effective any January 1. ZIP codes are subject to change by the U.S. Postal Service. The ZIP codes below for each county are in our Service Area:

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

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

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

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

Services: Health care services or items ("health care" includes both physical health care and mental health care) and services to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness.

Severe Mental Illness: The following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Spouse: The person to whom the Subscriber is legally married under applicable law. For the purposes of this *EOC*, the term "Spouse" includes the Subscriber's domestic partner. "Domestic partners" are two people who are registered and legally recognized as domestic partners by California (if your Group allows enrollment of domestic partners not legally recognized as domestic partners by California, "Spouse" also includes the Subscriber's domestic partner who meets your Group's eligibility requirements for domestic partners).

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant person who is having contractions, when there is inadequate time to safely transfer them to another hospital before delivery (or the transfer may pose a threat to the health or safety of the pregnant person or unborn child), "Stabilize" means to deliver (including the placenta).

Subscriber: A Member who is eligible for membership on their own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

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

Telehealth Visits: Interactive video visits and scheduled telephone visits between you and your provider.

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.

Premiums, Eligibility, and Enrollment

Premiums

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

If you don't have Medicare Part A, you may be eligible to purchase Medicare Part A from Social Security. Please contact Social Security for more information. If you get Medicare Part A, this may reduce the amount you would be expected to pay to your Group, please check with your Group's benefits administrator.

Medicare Premiums

Medicare Part D Late Enrollment Penalty

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

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

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

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

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

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

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

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

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

Income Related Monthly Adjustment Amount

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

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

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

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

Who Is Eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this "Who Is Eligible" section, including your Group's eligibility requirements and your Home Region Service Area eligibility requirements.

Group eligibility requirements

You must meet your Group's eligibility requirements. Your Group is required to inform Subscribers of its eligibility requirements.

Senior Advantage eligibility requirements

- You must have Medicare Part B
- You must be a United States citizen or lawfully present in the United States
- Your Medicare coverage must be primary and your Group's health care plan must be secondary
- You may not be enrolled in another Medicare Health Plan or Medicare prescription drug plan

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

Service Area eligibility requirements

You must live in our Service Area, unless you have been continuously enrolled in Senior Advantage since December 31, 1998, and lived outside our Service Area during that entire time. In which case, you may continue your membership unless you move and are still outside your Home Region Service Area. The "Definitions" section describes our Service Area and how it may change.

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

Send your notice to:

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

It is in your best interest to notify us as soon as possible because until your Senior Advantage coverage is officially terminated by the Centers for Medicare & Medicaid Services, you will not be covered by us or Original Medicare for any care you receive from Non–Plan Providers, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Covered Services received outside of your Home Region Service Area as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Your Cost Share" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Your Cost Share" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section
- Routine Services associated with Medicare-approved clinical trials as described under "Services Associated with Clinical Trials" in the "Benefits and Your Cost Share" section

If you are not eligible to continue enrollment because you move to the service area of another Region, contact your Group to learn about your Group health care options. You may be able to enroll in the service area of another Region if there is an agreement between your Group and that Region, but the plan, including coverage,

premiums, and eligibility requirements, might not be the same as under this *EOC*.

For more information about the service areas of the other Regions, please call Member Services.

Eligibility as a Subscriber

You may be eligible to enroll and continue enrollment as a Subscriber if you are:

- An employee of your Group
- A proprietor or partner of your Group
- Otherwise entitled to coverage under a trust agreement, retirement benefit program, or employment contract (unless the Internal Revenue Service considers you self-employed)

Eligibility as a Dependent

Enrolling a Dependent

Dependent eligibility is subject to your Group's eligibility requirements, which are not described in this *EOC*. You can obtain your Group's eligibility requirements directly from your Group. If you are a Subscriber under this *EOC* and if your Group allows enrollment of Dependents, Health Plan allows the following persons to enroll as your Dependents under this *EOC*:

- Your Spouse
- Your or your Spouse's Dependent children, who meet the requirements described under "Age limit of Dependent children," if they are any of the following:
  - biological children
  - stepchildren
  - adopted children
  - children placed with you for adoption
  - foster children if you or your Spouse have the legal authority to direct their care
  - children for whom you or your Spouse is the court-appointed guardian (or was when the child reached age 18)
- Children whose parent is a Dependent child under your family coverage (including adopted children and children placed with your Dependent child for adoption or foster care) if they meet all of the following requirements:
  - they are not married and do not have a domestic partner (for the purposes of this requirement only, "domestic partner" means someone who is registered and legally recognized as a domestic partner by California)
  - they meet the requirements described under "Age limit of Dependent children"
  - they receive all of their support and maintenance from you or your Spouse
  - they permanently reside with you or your Spouse

Age limit of Dependent children

Children must be under age 26 as of the effective date of this *EOC* to enroll as a Dependent under your plan.

Dependent children are eligible to remain on the plan through the end of the month in which they reach the age limit.

Dependent children of the Subscriber or Spouse (including adopted children and children placed with you for adoption or foster care) who reach the age limit may continue coverage under this *EOC* if all of the following conditions are met:

- They meet all requirements to be a Dependent except for the age limit
- Your Group permits enrollment of Dependents
- They are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred before they reached the age limit for Dependents
- They receive 50 percent or more of their support and maintenance from you or your Spouse
- If requested, you give us proof of their incapacity and dependency within 60 days after receiving our request (see "Overage Dependent certification" below in this "Eligibility as a Dependent" section)

Overage Dependent certification

Proof may be required for a Dependent to be eligible to continue coverage as an overage Dependent. If we request it, the Subscriber must provide us documentation of the dependent's incapacity and dependency as follows:

- If the child is a Member, we will send the Subscriber a notice of the Dependent's membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. The Dependent's membership will terminate as described in our notice unless the Subscriber provides us documentation of the Dependent's incapacity and dependency within 60 days of receipt of our notice and we determine that the Dependent is eligible as an overage dependent. If the Subscriber provides us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that the Dependent does not meet the eligibility requirements as an overage dependent, we will notify the

Subscriber that the Dependent is not eligible and let the Subscriber know the membership termination date. If we determine that the Dependent is eligible as an overage dependent, there will be no lapse in coverage. Also, starting two years after the date that the Dependent reached the age limit, the Subscriber must provide us documentation of the Dependent's incapacity and dependency annually within 60 days after we request it so that we can determine if the Dependent continues to be eligible as an overage dependent

- If the child is not a Member because you are changing coverage, you must give us proof, within 60 days after we request it, of the child's incapacity and dependency as well as proof of the child's coverage under your prior coverage. In the future, you must provide proof of the child's continued incapacity and dependency within 60 days after you receive our request, but not more frequently than annually

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

How to Enroll and When Coverage Begins

Your Group is required to inform you when you're eligible to enroll and what your effective date of coverage is. If you're eligible to enroll as described under "Who Is Eligible" in this "Premiums, Eligibility, and Enrollment" section, enrollment is permitted as described below and membership begins at the beginning (12:00 a.m.) of the effective date of coverage indicated below, except that:

- Your Group may have additional requirements, which allow enrollment in other situations
- The effective date of your Senior Advantage coverage under this *EOC* must be confirmed by the Centers for Medicare & Medicaid Services, as described under "Effective date of Senior Advantage coverage" in this "How to Enroll and When Coverage Begins" section

If you're a Subscriber under this *EOC* and you have dependents who don't have Medicare Part B coverage or for some other reason aren't eligible to enroll under this *EOC*, you may be able to enroll them as your dependents under a non-Medicare plan offered by your Group. Contact your Group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

If you're eligible to be a Dependent under this *EOC* but the subscriber in your family is enrolled under a non-Medicare plan offered by your Group, the subscriber must follow the rules applicable to Subscribers who are enrolling Dependents in this "How to Enroll and When Coverage Begins" section.

Effective date of Senior Advantage coverage

After we receive your completed Senior Advantage Election Form, we'll submit your enrollment request to the Centers for Medicare & Medicaid Services for confirmation and send you a notice indicating the proposed effective date of your Senior Advantage coverage under this *EOC*.

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

New employees

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person, to your Group within 31 days.

Effective date of Senior Advantage coverage. The effective date of Senior Advantage coverage for new employees and their eligible family Dependents or newly acquired Dependents, is determined by your Group, subject to confirmation by the Centers for Medicare & Medicaid Services.

Group open enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person (or through an alternate, approved electronic process) to your Group during your Group's open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the effective date of coverage, which is subject to confirmation by the Centers for Medicare & Medicaid Services.

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

- You become eligible because you experience a qualifying event (sometimes called a "triggering event") as described in this "Special enrollment" section
- You did not enroll in any coverage offered by your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, from the Subscriber

Special enrollment due to new Dependents

You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, within 30 days after marriage, establishment of domestic partnership, birth, adoption, placement for adoption, or placement for foster care by submitting to your Group a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person.

Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application, and a Senior Advantage Election Form for each person, from the Subscriber. Subject to confirmation by the Centers for Medicare & Medicaid Services, enrollments of newly acquired Dependent children are effective as follows:

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

Special enrollment due to loss of other coverage. You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, if all of the following are true:

- The Subscriber or at least one of the Dependents had other coverage when they previously declined all coverage through your Group
- The loss of the other coverage is due to one of the following:
  - ♦ exhaustion of COBRA coverage
  - ♦ termination of employer contributions for non-COBRA coverage
  - ♦ loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, moving out of the plan's Service Area, reaching the age limit for dependent children, or the subscriber's death, termination of employment, or reduction in hours of employment
  - ♦ loss of eligibility (but not termination for cause) for coverage through Covered California, Medicaid coverage (known as Medi-Cal in California), Children's Health Insurance Program coverage, or Medi-Cal Access Program coverage
  - ♦ reaching a lifetime maximum on all benefits

Note: If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, only one of you must meet the requirements stated above.

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, to your Group within 30 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for coverage through Covered California, Medicaid, Children's Health Insurance Program, or Medi-Cal Access Program coverage. Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application, and Senior Advantage Election Form for each person, from the Subscriber.

Special enrollment due to court or administrative order. Within 31 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved

enrollment or change of enrollment application, and a Senior Advantage Election Form for each person.

Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of coverage resulting from a court or administrative order is the first of the month following the date we receive the enrollment request, unless your Group specifies a different effective date (if your Group specifies a different effective date, the effective date cannot be earlier than the date of the order).

Special enrollment due to eligibility for premium assistance. You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, if you or a dependent become eligible for premium assistance through the Medi-Cal program. Premium assistance is when the Medi-Cal program pays all or part of premiums for employer group coverage for a Medi-Cal beneficiary. To request enrollment in your Group's health care coverage, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, to your Group within 60 days after you or a dependent become eligible for premium assistance. Please contact the California Department of Health Care Services to find out if premium assistance is available and the eligibility requirements.

Special enrollment due to reemployment after military service. If you terminated your health care coverage because you were called to active duty in the military service, you may be able to reenroll in your Group's health plan if required by state or federal law. Please ask your Group for more information.

How to Obtain Services

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Services" section
- Covered Services received outside of your Home Region Service Area as described under "Receiving Care Outside of Your Home Region Service Area" in this "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Your Cost Share" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Your Cost Share" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section
- Routine Services associated with Medicare-approved clinical trials as described under "Services Associated with Clinical Trials" in the "Benefits and Your Cost Share" section

Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital Services, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *EOC*.

Routine Care

To request a non-urgent appointment, you can call your local Plan Facility or request the appointment online. For appointment phone numbers, refer to our Provider Directory or call Member Services. To request an appointment online, go to our website at **kp.org**.

Urgent Care

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call Member Services.

For information about Out-of-Area Urgent Care, refer to "Urgent Care" in the "Emergency Services and Urgent Care" section.

Our Advice Nurses

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. Whether you are calling for advice or to make an appointment, you can speak to an advice nurse. They can often answer questions about a minor concern, tell you what to do if a Plan Medical

Office is closed, or advise you about what to do next, including making a same-day Urgent Care appointment for you if it's medically appropriate. To reach an advice nurse, refer to our Provider Directory or call Member Services.

Your Personal Plan Physician

Personal Plan Physicians provide primary care and play an important role in coordinating care, including hospital stays and referrals to specialists.

We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal Plan Physicians. However, if you choose a specialist who is not designated as a Primary Care Physician as your personal Plan Physician, the Cost Share for a Physician Specialist Visit will apply to all visits with the specialist except for Preventive Services listed in the "Benefits and Your Cost Share" section.

To learn how to select or change to a different personal Plan Physician, visit our website at **kp.org**, or call Member Services. Refer to our Provider Directory for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call Member Services. You can change your personal Plan Physician at any time for any reason.

Getting a Referral

Referrals to Plan Providers

A Plan Physician must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, dermatology, and physical, occupational, and speech therapies. However, you do not need a referral or prior authorization to receive most care from any of the following Plan Providers:

- Your personal Plan Physician
- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, mental health Services, substance use disorder treatment, and obstetrics/gynecology

A Plan Physician must refer you before you can get care from a specialist in urology except that you do not need a referral to receive Services related to sexual or reproductive health, such as a vasectomy.

Although a referral or prior authorization is not required to receive most care from these providers, a referral may be required in the following situations:

- The provider may have to get prior authorization for certain Services in accord with "Medical Group authorization procedure for certain referrals" in this "Getting a Referral" section
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition

Standing referrals

If a Plan Physician refers you to a specialist, the referral will be for a specific treatment plan. Your treatment plan may include a standing referral if ongoing care from the specialist is prescribed. For example, if you have a life-threatening, degenerative, or disabling condition, you can get a standing referral to a specialist if ongoing care from the specialist is required.

Medical Group authorization procedure for certain referrals

The following are examples of Services that require prior authorization by the Medical Group for the Services to be covered ("prior authorization" means that the Medical Group must approve the Services in advance):

- Durable medical equipment
- Ostomy and urological supplies
- Services not available from Plan Providers
- Transplants

Utilization Management ("UM") is a process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UM process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at **kp.org/UM** or call Member Services to request a printed copy. Refer to "Post-Stabilization Care" under "Emergency Services" in the "Emergency Services and Urgent Care" section for authorization requirements that apply to Post-Stabilization Care from Non–Plan Providers.

Additional information about prior authorization for durable medical equipment, ostomy, urological, and specialized wound care supplies. The prior authorization process for durable medical equipment, ostomy, urological, and specialized wound care supplies includes the use of formulary guidelines. These guidelines were developed by a multidisciplinary clinical and operational work group with review and input from Plan Physicians and medical professionals with clinical expertise. The formulary guidelines are periodically updated to keep pace with changes in medical technology, Medicare guidelines, and clinical practice.

If your Plan Physician prescribes one of these items, they will submit a written referral in accord with the UM process described in this "Medical Group authorization procedure for certain referrals" section. If the formulary guidelines do not specify that the prescribed item is appropriate for your medical condition, the referral will be submitted to the Medical Group's designee Plan Physician, who will make an authorization decision as described under "Medical Group's decision time frames" in this "Medical Group authorization procedure for certain referrals" section.

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

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your physician will be informed of the scope of the authorized Services. If the Medical Group does not authorize all of the Services, Health Plan will send you a written decision and explanation within two business days after the decision is made. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request.

If the Medical Group does not authorize all of the Services requested and you want to appeal the decision, you can file a grievance as described in the "Coverage Decisions, Appeals, and Complaints" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Travel and Lodging for Certain Services

The following are examples of when we will arrange or provide reimbursement for certain travel and lodging expenses in accord with our Travel and Lodging Program Description:

- If Medical Group refers you to a provider that is more than 50 miles from where you live for certain specialty Services such as bariatric surgery, complex thoracic surgery, transplant nephrectomy, or inpatient chemotherapy for leukemia and lymphoma
- If Medical Group refers you to a provider that is outside your Home Region Service Area for certain specialty Services such as a transplant or transgender surgery
- If you are outside of California and you need an abortion on an emergency or urgent basis, and the abortion can't be obtained in a timely manner due to a near total or total ban on health care providers' ability to provide such Services

For the complete list of specialty Services for which we will arrange or provide reimbursement for travel and lodging expenses, the amount of reimbursement, limitations and exclusions, and how to request reimbursement, refer to the Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at **kp.org/specialty-care/travel-reimbursements** or by calling Member Services.

Second Opinions

If you want a second opinion, you can ask Member Services to help you arrange one with a Plan Physician who is an appropriately qualified medical professional

for your condition. If there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, Member Services will help you arrange a consultation with a Non–Plan Physician for a second opinion. For purposes of this "Second Opinions" provision, an "appropriately qualified medical professional" is a physician who is acting within their scope of practice and who possesses a clinical background, including training and expertise, related to the illness or condition associated with the request for a second medical opinion.

Here are some examples of when a second opinion may be provided or authorized:

- Your Plan Physician has recommended a procedure and you are unsure about whether the procedure is reasonable or necessary
- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions
- The clinical indications are not clear or are complex and confusing
- A diagnosis is in doubt due to conflicting test results
- The Plan Physician is unable to diagnose the condition
- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have concerns about the diagnosis or plan of care

An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial and of your right to file a grievance as described in the "Coverage Decisions, Appeals, and Complaints" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Contracts with Plan Providers

How Plan Providers are paid

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Physicians are paid to provide or arrange medical and hospital Services for Members, please visit our website at **kp.org** or call Member Services.

Financial liability

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may have to pay the full price of noncovered Services you obtain from Plan Providers or Non–Plan Providers.

When you are referred to a Plan Provider for covered Services, you pay the Cost Share required for Services from that provider as described in this *EOC*.

Termination of a Plan Provider's contract and completion of Services

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for the covered Services you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements.

Completion of Services. If you're undergoing treatment for specific conditions from a Plan Physician (or certain other providers) when the contract with them ends (for reasons other than medical disciplinary cause, criminal activity, or the provider's voluntary termination), you may be eligible to continue receiving covered care from the terminated provider for your condition. The conditions that are subject to this continuation of care provision are:

- Certain conditions that are either acute, or serious and chronic. We may cover these Services for up to 90 days, or longer, if necessary for a safe transfer of care to a Plan Physician or other contracting provider as determined by the Medical Group
- A high-risk pregnancy or a pregnancy in its second or third trimester. We may cover these Services through postpartum care related to the delivery, or longer if Medically Necessary for a safe transfer of care to a Plan Physician as determined by the Medical Group

The Services must be otherwise covered under this *EOC*. Also, the terminated provider must agree in writing to our contractual terms and conditions and comply with them for Services to be covered by us.

For the Services of a terminated provider, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

More information. For more information about this provision, or to request the Services, call Member Services.

Receiving Care Outside of Your Home Region Service Area

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

Receiving care in another Kaiser Permanente service area

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

Receiving care outside of any Kaiser Permanente service area

If you are traveling outside of any Kaiser Permanente service area, we cover Services as described in the "Emergency Services and Urgent Care" section about Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care and the "Benefits and Your Cost Share" section about out-of-area dialysis care.

Your ID Card

Each Member's Kaiser Permanente ID card has a medical record number on it, which you will need when you call for advice, make an appointment, or go to a provider for covered care. When you get care, please bring your Kaiser Permanente ID card and a photo ID. Your medical record number is used to identify your medical records and membership information. Your medical record number should never change. Please call Member Services if we ever inadvertently issue you more than one medical record number or if you need to replace your Kaiser Permanente ID card.

Your ID card is for identification only. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-Member for any Services they receive. If you let someone else use your ID card, we may keep your ID card and terminate your membership as described under "Termination for Cause" in the "Termination of Membership" section.

Your Medicare card

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

Getting Assistance

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your personal Plan Physician or with other Plan Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Member Services

Member Services representatives can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain the following:

- Your Health Plan benefits
- How to make your first medical appointment
- What to do if you move
- How to replace your Kaiser Permanente ID card

Many Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, Member Services representatives are available to assist you seven days a week from 8 a.m. to 8 p.m. toll free at **1-800-443-0815** or **711** (TTY for the deaf, hard of hearing, or speech impaired). For your convenience, you can also contact us through our website at **kp.org**.

Cost Share estimates

For information about estimates, see "Getting an estimate of your Cost Share" under "Your Cost Share" in the "Benefits and Your Cost Share" section.

Plan Facilities

Plan Medical Offices and Plan Hospitals are listed in the Provider Directory for your Home Region. The directory describes the types of covered Services that are available from each Plan Facility, because some facilities provide

only specific types of covered Services. This directory is available on our website at **kp.org/facilities**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call Member Services.

At most of our Plan Facilities, you can usually receive all of the covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you:

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available from Plan Hospital Emergency Departments (for Emergency Department locations, refer to our Provider Directory or call Member Services)
- Same-day Urgent Care appointments are available at many locations (for Urgent Care locations, refer to our Provider Directory or call Member Services)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services office (for locations, refer to our Provider Directory or call Member Services)
- Plan Pharmacies are located at most Plan Medical Offices (for pharmacy locations, refer to our Pharmacy Directory or call Member Services)

Provider Directory

The Provider Directory lists our Plan Providers. It is subject to change and periodically updated. If you don't have our Provider Directory, you can get a copy by calling Member Services or by visiting our website at **kp.org/directory**.

Pharmacy Directory

The Pharmacy Directory lists the locations of Plan Pharmacies, which are also called "network pharmacies." The pharmacy directory provides additional information about obtaining prescription drugs. It is subject to change and periodically updated. If you don't have the Pharmacy Directory, you can get a copy by calling Member Services or by visiting our website at **kp.org/directory**.

Emergency Services and Urgent Care

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest Emergency Department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non–Plan Providers anywhere in the world.

Emergency Services are available from Plan Hospital Emergency Departments 24 hours a day, seven days a week.

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that your condition is Stabilized.

To request prior authorization, the Non–Plan Provider must call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card *before* you receive the care. We will discuss your condition with the Non–Plan Provider. If we determine that you require Post-Stabilization Care and that this care is part of your covered benefits, we will authorize your care from the Non–Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care with the treating physician's concurrence. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated Non–Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered.

Be sure to ask the Non–Plan Provider to tell you what care (including any transportation) we have authorized because we will not cover unauthorized Post-Stabilization Care or related transportation provided by Non–Plan Providers. If you receive care from a Non–Plan Provider that we have not authorized, you may have to pay the full cost of that care if you are notified by the Non–Plan Provider or us about your potential liability.

Your Cost Share

Your Cost Share for covered Emergency Services and Post-Stabilization Care is described in the "Benefits and Your Cost Share" section. Your Cost Share is the same

whether you receive the Services from a Plan Provider or a Non–Plan Provider. For example:

- If you receive Emergency Services in the Emergency Department of a Non–Plan Hospital, you pay the Cost Share for an Emergency Department visit as described under "Outpatient Care"
- If we gave prior authorization for inpatient Post-Stabilization Care in a Non–Plan Hospital, you pay the Cost Share for hospital inpatient care as described under "Hospital Inpatient Care"

Urgent Care

Inside your Home Region Service Area

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For appointment and advice phone numbers, refer to our Provider Directory or call Member Services.

In the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC* (such as a major disaster, epidemic, war, riot, and civil insurrection), we cover Urgent Care inside our Service Area from a Non–Plan Provider.

Out-of-Area Urgent Care

If you need Urgent Care due to an unforeseen illness or unforeseen injury, we cover Medically Necessary Services to prevent serious deterioration of your health from a Non–Plan Provider if all of the following are true:

- You receive the Services from Non–Plan Providers while you are temporarily outside our Service Area
- A reasonable person would have believed that your health would seriously deteriorate if you delayed treatment until you returned to our Service Area

You do not need prior authorization for Out-of-Area Urgent Care. We cover Out-of-Area Urgent Care you receive from Non–Plan Providers if the Services would have been covered under this *EOC* if you had received them from Plan Providers.

We do not cover follow-up care from Non–Plan Providers after you no longer need Urgent Care. To obtain follow-up care from a Plan Provider, call the appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call Member Services.

Your Cost Share

Your Cost Share for covered Urgent Care is the Cost Share required for Services provided by Plan Providers as described in this *EOC*. For example:

- If you receive an Urgent Care evaluation as part of covered Out-of-Area Urgent Care from a Non–Plan Provider, you pay the Cost Share for Urgent Care consultations, evaluations, and treatment as described under "Outpatient Care"
- If the Out-of-Area Urgent Care you receive includes an X-ray, you pay the Cost Share for an X-ray as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services" in addition to the Cost Share for the Urgent Care evaluation

Note: If you receive Urgent Care in an Emergency Department, you pay the Cost Share for an Emergency Department visit as described under "Outpatient Care."

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Urgent Care from a Non–Plan Provider as described in this "Emergency Services and Urgent Care" section, or emergency ambulance Services described under "Ambulance Services" in the "Benefits and Your Cost Share" section, ask the Non–Plan Provider to submit a claim to us within 60 days or as soon as possible, but no later than 15 months after receiving the care (or up to 27 months according to Medicare rules, in some cases). If the provider refuses to bill us, send us the unpaid bill with a claim form. Also, if you receive Services from a Plan Provider that are prescribed by a Non–Plan Provider as part of covered Emergency Services, Post-Stabilization Care, and Urgent Care (for example, drugs), you may be required to pay for the Services and file a claim. To request payment or reimbursement, you must file a claim as described in the "Requests for Payment" section.

We will reduce any payment we make to you or the Non–Plan Provider by the applicable Cost Share. Also, in accord with applicable law, we will reduce our payment by any amounts paid or payable (or that in the absence of this plan would have been payable) for the Services under any insurance policy, or any other contract or coverage, or any government program except Medicaid.

Benefits and Your Cost Share

This section describes the Services that are covered under this *EOC*.

Services are covered under this *EOC* as specifically described in this *EOC*. Services that are not specifically described in this *EOC* are not covered, except as required by federal law. Services are subject to exclusions and limitations described in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. Except as otherwise described in this *EOC*, all of the following conditions must be satisfied:

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
  - Preventive Services
  - health care items and services for diagnosis, assessment, or treatment
  - health education covered under "Health Education" in this "Benefits and Your Cost Share" section
  - other health care items and services
  - other services to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except for:
  - covered Services received outside of your Home Region Service Area, as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
  - drugs prescribed by dentists, as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section
  - emergency ambulance Services, as described under "Ambulance Services" in this "Benefits and Your Cost Share" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
  - eyeglasses and contact lenses prescribed by Non–Plan Providers, as described under "Vision Services" in this "Benefits and Your Cost Share" section
  - out-of-area dialysis care, as described under "Dialysis Care" in this "Benefits and Your Cost Share" section
  - routine Services associated with Medicare-approved clinical trials, as described under "Services Associated with Clinical Trials" in this "Benefits and Your Cost Share" section
- You receive the Services from Plan Providers inside our Service Area, except for:
  - authorized referrals, as described under "Getting a Referral" in the "How to Obtain Services" section
  - covered Services received outside of your Home Region Service Area, as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
  - emergency ambulance Services, as described under "Ambulance Services" in this "Benefits and Your Cost Share" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
  - out-of-area dialysis care, as described under "Dialysis Care" in this "Benefits and Your Cost Share" section
  - prescription drugs from Non–Plan Pharmacies, as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section
  - routine Services associated with Medicare-approved clinical trials, as described under "Services Associated with Clinical Trials" in this "Benefits and Your Cost Share" section
- The Medical Group has given prior authorization for the Services, if required, as described under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

Please also refer to:

- The "Emergency Services and Urgent Care" section for information about how to obtain covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care
- Our Provider Directory for the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services

Your Cost Share

Your Cost Share is the amount you are required to pay for covered Services. The Cost Share for covered Services is listed in this *EOC*. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible.

General rules, examples, and exceptions

Your Cost Share for covered Services will be the Cost Share in effect on the date you receive the Services, except as follows:

- If you are receiving covered hospital inpatient Services on the effective date of this *EOC*, you pay the Cost Share in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Share in effect on the date you receive the Services
- For items ordered in advance, you pay the Cost Share in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Share when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription

Payment toward your Cost Share (and when you may be billed)

In most cases, your provider will ask you to make a payment toward your Cost Share at the time you receive Services. If you receive more than one type of Services (such as primary care treatment and laboratory tests), you may be required to pay separate Cost Share for each of those Services. Keep in mind that your payment toward your Cost Share may cover only a portion of your total Cost Share for the Services you receive, and you will be billed for any additional amounts that are due. The following are examples of when you may be asked to pay (or you may be billed for) Cost Share amounts in addition to the amount you pay at check-in:

- You receive non-preventive Services during a preventive visit. For example, you go in for a routine physical exam, and at check-in you pay your Cost Share for the preventive exam (your Cost Share may be "no charge"). However, during your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional non-preventive diagnostic Services
- You receive diagnostic Services during a treatment visit. For example, you go in for treatment of an existing health condition, and at check-in you pay your Cost Share for a treatment visit. However, during the visit your provider finds a new problem with your health and performs or orders diagnostic Services (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional diagnostic Services
- You receive treatment Services during a diagnostic visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider confirms a problem with your health and performs treatment Services (such as an outpatient procedure). You may be asked to pay (or you will be billed for) your Cost Share for these additional treatment Services
- You receive Services from a second provider during your visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay (or you will be billed for) your Cost Share for the consultation with the specialist

In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for your Cost Share (for example, some Laboratory Departments are not able to collect Cost Shares).

When we send you a bill, it will list Charges for the Services you received, payments and credits applied to your account, and any amounts you still owe. Your current bill may not always reflect your most recent Charges and payments. Any Charges and payments that are not on the current bill will appear on a future bill. Sometimes, you may see a payment but not the related Charges for Services. That could be because your payment was recorded before the Charges for the Services were processed. If so, the Charges will appear on a future bill. Also, you may receive more than one bill for a single outpatient visit or inpatient stay. For example, you may receive a bill for physician services and a separate bill for hospital services. If you don't see all the Charges for Services on one bill, they will appear on a future bill. If we determine that you overpaid and are due a refund, then we will send a refund to you within four weeks after we make that determination. If you have questions about a bill, please call the phone number on the bill.

In some cases, a Non–Plan Provider may be involved in the provision of covered Services at a Plan Facility or a contracted facility where we have authorized you to receive care. You are not responsible for any amounts beyond your Cost Share for the covered Services you receive at Plan Facilities or at contracted facilities where we have authorized you to receive care. However, if the

provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Requests for Payment" section.

Primary Care Visits, Non-Physician Specialist Visits, and Physician Specialist Visits. The Cost Share for a Primary Care Visit applies to evaluations and treatment provided by generalists in internal medicine, pediatrics, or family practice, and by specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Some physician specialists provide primary care in addition to specialty care but are not designated as Primary Care Physicians. If you receive Services from one of these specialists, the Cost Share for a Physician Specialist Visit will apply to all consultations, evaluations, and treatment provided by the specialist except for routine preventive counseling and exams listed under "Preventive Services" in this "Benefits and Your Cost Share" section. For example, if your personal Plan Physician is a specialist in internal medicine or obstetrics/gynecology who is not a Primary Care Physician, you will pay the Cost Share for a Physician Specialist Visit for all consultations, evaluations, and treatment by the specialist except routine preventive counseling and exams listed under "Preventive Services" in this "Benefits and Your Cost Share" section. The Non-Physician Specialist Visit Cost Share applies to consultations, evaluations, and treatment provided by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

Provider fees

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

Noncovered services

If you receive services that are not covered under this *EOC*, you may have to pay the full price of those services. Payments you make for noncovered services do not apply to any deductible or out-of-pocket maximum.

Getting an estimate of your Cost Share

If you have questions about the Cost Share for specific Services that you expect to receive or that your provider orders during a visit or procedure, please visit our website at **kp.org** to use our cost estimate tool or call Member Services.

- If you have a Plan Deductible and would like an estimate for Services that are subject to the Plan Deductible, please call **1-800-390-3507** (TTY users call **711**) Monday through Friday, 6 a.m. to 5 p.m.
- For all other Cost Share estimates, please call Member Services

Cost Share estimates are based on your benefits and the Services you expect to receive. They are a prediction of cost and not a guarantee of the final cost of Services. Your final cost may be higher or lower than the estimate since not everything about your care can be known in advance.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service, after you meet any applicable deductible, is described in this *EOC*.

Note: If Charges for Services are less than the Copayment or Coinsurance described in this *EOC*, you will pay the lesser amount.

Plan Out-of-Pocket Maximum

There is a limit to the total amount of Cost Share you must pay under this *EOC* in the calendar year for certain covered Services that you receive in the same calendar year. The Services that apply to the Plan Out-of-Pocket Maximum are described under the "Payments that count toward the Plan Out-of-Pocket Maximum" section below. The limit is **$1,000** per calendar year for any one Member.

For Services subject to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share during the remainder of the calendar year, but every other Member in your Family must continue to pay Cost Share during the remainder of the calendar year until they each reach the **$1,000** maximum.

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

- Covered in-network Medicare Part A and Part B Services
- Medicare Part B drugs (all other drugs do not apply)
- Residential treatment program Services covered in the "Substance Use Disorder Treatment" and "Mental Health Services" sections

Copayments and Coinsurance you pay for Services that are not described above, do not apply to the Plan Out-of-Pocket Maximum. For those Services, you must continue to pay Copayments or Coinsurance even if you have already reached the Plan Out-of-Pocket Maximum. In

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

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

Outpatient Care

We cover the following outpatient care subject to the Cost Share indicated:

Office visits

- Primary Care Visits and Non-Physician Specialist Visits that are not described elsewhere in this *EOC*: **a $20 Copayment per visit**
- Physician Specialist Visits that are not described elsewhere in this *EOC*: **a $20 Copayment per visit**
- Outpatient visits that are available as group appointments that are not described elsewhere in this *EOC*: **a $10 Copayment per visit**
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician:
  - Primary Care Visits and Non-Physician Specialist Visits: **a $20 Copayment per visit**
  - Physician Specialist Visits: **a $20 Copayment per visit**
- Routine physical exams that are medically appropriate preventive care in accord with generally accepted professional standards of practice: **no charge**
- Family planning counseling, or internally implanted time-release contraceptives or intrauterine devices (IUDs) and office visits related to their administration and management: **a $20 Copayment per visit**
- After confirmation of pregnancy, the normal series of regularly scheduled preventive prenatal care exams and the first postpartum follow-up consultation and exam: **a $15 Copayment per visit**
- Voluntary termination of pregnancy and related Services: **no charge**
- Physical, occupational, and speech therapy in accord with Medicare guidelines: **a $20 Copayment per visit**
- Group and individual physical therapy prescribed by a Plan Provider to prevent falls: **no charge**
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program in accord with Medicare guidelines: **a $20 Copayment per day**
- Manual manipulation of the spine to correct subluxation, in accord with Medicare guidelines, is covered by a participating chiropractor of the American Specialty Health Plans of California, Inc. (ASH Plans): **a $20 Copayment per visit**. (A referral by a Plan Physician is not required. For the list of participating ASH Plans providers, refer to the Provider Directory)

Acupuncture Services

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

Emergency Services and Urgent Care

- Urgent Care consultations, evaluations, and treatment: **a $20 Copayment per visit**
- Emergency Department visits: **a $50 Copayment per visit**

If you are admitted from the Emergency Department. If you are admitted to the hospital as an inpatient for covered Services (either within 24 hours for the same condition or after an observation stay), then the Services you received in the Emergency Department and observation stay, if applicable, will be considered part of your inpatient hospital stay. For the Cost Share for inpatient care, refer to "Hospital Inpatient Services" in this "Benefits and Your Cost Share" section. However, the Emergency Department Cost Share does apply if you are admitted for observation but are not admitted as an inpatient.

Outpatient surgeries and procedures

- Outpatient surgery and outpatient procedures when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **a $50 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a $20 Copayment per procedure**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this "Benefits and Your Cost Share" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Pre- and post-operative visits:
  - Primary Care Visits and Non-Physician Specialist Visits: **a $20 Copayment per visit**
  - Physician Specialist Visits: **a $20 Copayment per visit**

Administered drugs and products

Administered drugs and products are medications and products that require administration or observation by medical personnel. We cover these items when prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility or during home visits.

We cover the following Services and their administration in a Plan Facility at the Cost Share indicated:

- Whole blood, red blood cells, plasma, and platelets: **no charge**
- Allergy antigens (including administration): **a $3 Copayment per visit**
- Cancer chemotherapy drugs and adjuncts: **no charge**
- Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products ("biologics") derived from tissue, cells, or blood: **no charge**
- Tuberculosis skin tests: **no charge**
- All other administered drugs and products: **no charge**

We cover drugs and products administered to you during a home visit at **no charge**.

Certain administered drugs are Preventive Services. Refer to "Preventive Services" in this "Benefits and Your Cost Share" section for information on immunizations.

Note: Vaccines covered by Medicare Part D are not covered under this "Outpatient Care" section (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section).

For the following Services, refer to these sections

- Bariatric Surgery
- Dental Services
- Dialysis Care
- Durable Medical Equipment ("DME") for Home Use
- Fertility Services
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Mental Health Services
- Ostomy, Urological, and Specialized Wound Care Supplies
- Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services
- Outpatient Prescription Drugs, Supplies, and Supplements
- Preventive Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Substance Use Disorder Treatment
- Transplant Services
- Vision Services

Hospital Inpatient Services

We cover the following inpatient Services in a Plan Hospital, when the Services are generally and

customarily provided by acute care general hospitals inside our Service Area:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Plan Physicians, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and other diagnostic and treatment Services, including MRI, CT, and PET scans
- Whole blood, red blood cells, plasma, platelets, and their administration
- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge (for visits after you are released from the hospital, please refer to "Outpatient Care" in this "Benefits and Your Cost Share" section)
- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program) in accord with Medicare guidelines
- Respiratory therapy
- Medical social services and discharge planning

Your Cost Share. We cover hospital inpatient Services at **a $500 Copayment per admission**.

For the following Services, refer to these sections

- Bariatric surgical procedures (refer to "Bariatric Surgery")
- Dental procedures (refer to "Dental Services")
- Dialysis care (refer to "Dialysis Care")
- Fertility Services related to diagnosis and treatment of infertility, artificial insemination, or assisted reproductive technology (refer to "Fertility Services")
- Hospice care (refer to "Hospice Care")
- Mental health Services (refer to "Mental Health Services")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Reconstructive surgery Services (refer to "Reconstructive Surgery")
- Religious Nonmedical Health Care Institution Services (refer to "Religious Nonmedical Health Care Institution")
- Services in connection with a clinical trial (refer to "Services in Connection with a Clinical Trial")
- Skilled inpatient Services in a Plan Skilled Nursing Facility (refer to "Skilled Nursing Facility Care")
- Substance use disorder treatment Services (refer to "Substance Use Disorder Treatment")
- Transplant Services (refer to "Transplant Services")

Ambulance Services

Emergency

We cover Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

- You reasonably believed that the medical condition was an Emergency Medical Condition which required ambulance Services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

If you receive emergency ambulance Services that are not ordered by a Plan Provider, you are not responsible for any amounts beyond your Cost Share for covered emergency ambulance Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Requests for Payment" section.

Nonemergency

Inside our Service Area, we cover nonemergency ambulance Services in accord with Medicare guidelines if a Plan Physician determines that your condition requires the use of Services that only a licensed

ambulance can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to and from qualifying locations as defined by Medicare guidelines.

Your Cost Share

You pay the following for covered ambulance Services:

- Emergency ambulance Services: **a $100 Copayment per trip**
- Nonemergency Services: **a $100 Copayment per trip**

Ambulance Services exclusions

- Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider

Bariatric Surgery

We cover hospital inpatient Services related to bariatric surgical procedures (including room and board, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

- You complete the Medical Group–approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success
- A Plan Physician who is a specialist in bariatric care determines that the surgery is Medically Necessary

Your Cost Share. For covered Services related to bariatric surgical procedures that you receive, you will pay the **Cost Share you would pay if the Services were not related to a bariatric surgical procedure**. For example, see "Hospital Inpatient Services" in this "Benefits and Your Cost Share" section for the Cost Share that applies for hospital inpatient Services.

For the following Services, refer to these sections

- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Dental Services

In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. Dental Services must be approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

Dental anesthesia

For dental procedures at a Plan Facility, we provide general anesthesia and the facility's Services associated with the anesthesia if all of the following are true:

- You are under age 7, or you are developmentally disabled, or your health is compromised
- Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
- The dental procedure would not ordinarily require general anesthesia

We do not cover any other Services related to the dental procedure, such as the dentist's Services, unless the Service is covered in accord with Medicare guidelines.

Your Cost Share

You pay the following for dental Services covered under this "Dental Services" section:

- Non-Physician Specialist Visits with dentists for Services covered under this "Dental Services" section: **a $20 Copayment per visit**
- Physician Specialist Visits for Services covered under this "Dental Services" section: **a $20 Copayment per visit**
- Outpatient surgery and outpatient procedures when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **a $50 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a $20 Copayment per procedure**

- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this "Benefits and Your Cost Share" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services): **a $500 Copayment per admission**

For the following Services, refer to these sections

- Office visits not described in this "Dental Services" section (refer to "Outpatient Care")
- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Dialysis Care

We cover acute and chronic dialysis Services if all of the following requirements are met:

- You satisfy all medical criteria developed by the Medical Group
- The facility is certified by Medicare
- A Plan Physician provides a written referral for your dialysis treatment except for out-of-area dialysis care

We also cover hemodialysis and peritoneal home dialysis (including equipment, training, and medical supplies). Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

Out-of-area dialysis care

We cover dialysis (kidney) Services that you get at a Medicare-certified dialysis facility when you are temporarily outside our Service Area. If possible, before you leave the Service Area, please let us know where you are going so we can help arrange for you to have maintenance dialysis while outside our Service Area.

The procedure for obtaining reimbursement for out-of-area dialysis care is described in the "Requests for Payment" section.

Your Cost Share. You pay the following for these covered Services related to dialysis:

- Equipment and supplies for home hemodialysis and home peritoneal dialysis: **no charge**
- One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment: **no charge**
- Hemodialysis and peritoneal dialysis treatment: **no charge**
- Hospital inpatient Services (including room and board, drugs, imaging, laboratory, and other diagnostic and treatment Services, and Plan Physician Services): **a $500 Copayment per admission**

For the following Services, refer to these sections

- Durable medical equipment for home use (refer to "Durable Medical Equipment ("DME") for Home Use")
- Hospital inpatient Services (refer to "Hospital Inpatient Services")
- Office visits not described in this "Dialysis Care" section (refer to "Outpatient Care")
- Kidney disease education (refer to "Health Education")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")
- Telehealth Visits (refer to "Telehealth Visits")

Dialysis care exclusions

- Comfort, convenience, or luxury equipment, supplies and features
- Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

Durable Medical Equipment ("DME") for Home Use

DME coverage rules

DME for home use is an item that meets the following criteria:

- The item is intended for repeated use
- The item is primarily and customarily used to serve a medical purpose
- The item is generally useful only to an individual with an illness or injury
- The item is appropriate for use in the home (or another location used as your home as defined by Medicare)
- The item is expected to last at least 3 years

For a DME item to be covered, all of the following requirements must be met:

- Your *EOC* includes coverage for the requested DME item
- A Plan Physician has prescribed the DME item for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor.

DME for diabetes

We cover the following diabetes testing supplies and equipment and insulin-administration devices if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met:

- Glucose monitors for diabetes testing and their supplies (such as glucose monitor test strips, lancets, and lancet devices)
- Insulin pumps and supplies to operate the pump

Your Cost Share. You pay the following for covered DME for diabetes (including repair or replacement of covered equipment):

- Glucose monitors for diabetes testing and their supplies (such as glucose monitor test strips, lancets, and lancet devices): **no charge**
- Insulin pumps and supplies to operate the pump: **20 percent Coinsurance**

Base DME Items

We cover Base DME Items (including repair or replacement of covered equipment) if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met. "Base DME Items" means the following items:

- Glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Bone stimulator
- Canes (standard curved handle or quad) and replacement supplies
- Cervical traction (over door)
- Crutches (standard or forearm) and replacement supplies
- Dry pressure pad for a mattress
- Infusion pumps (such as insulin pumps) and supplies to operate the pump
- IV pole
- Nebulizer and supplies
- Phototherapy blankets for treatment of jaundice in newborns

Your Cost Share. You pay the following for covered Base DME Items: **20 percent Coinsurance**.

Other covered DME items

If all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met, we cover the following other DME items (including repair or replacement of covered equipment):

- Bed accessories for a hospital bed when bed extension is required
- Heel or elbow protectors to prevent or minimize advanced pressure relief equipment use
- Iontophoresis device to treat hyperhidrosis when antiperspirants are contraindicated and the hyperhidrosis has created medical complications (for example, skin infection) or preventing daily living activities
- Nontherapeutic continuous glucose monitoring devices and related supplies
- Peak flow meters

- Resuscitation bag if tracheostomy patient has significant secretion management problems, needing lavage and suction technique aided by deep breathing via resuscitation bag

Your Cost Share. You pay the following for other covered DME items: **20 percent Coinsurance**, except peak flow meters are covered at: **no charge**.

Outside our Service Area

We do not cover most DME for home use outside our Service Area. However, if you live outside our Service Area, we cover the following DME (subject to the Cost Share and all other coverage requirements that apply to DME for home use inside our Service Area) when the item is dispensed at a Plan Facility:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices) from a Plan Pharmacy
- Canes (standard curved handle)
- Crutches (standard)
- Nebulizers and their supplies for the treatment of pediatric asthma
- Peak flow meters from a Plan Pharmacy

For the following Services, refer to these sections

- Dialysis equipment and supplies required for home hemodialysis and home peritoneal dialysis (refer to "Dialysis Care")
- Diabetes urine testing supplies and insulin-administration devices other than insulin pumps (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Durable medical equipment related to the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Insulin and any other drugs administered with an infusion pump (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

DME for home use exclusions

- Comfort, convenience, or luxury equipment or features
- Dental appliances
- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including devices intended to provide additional support for recreational or sports activities)
- Hygiene equipment
- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car, unless covered in accord with Medicare guidelines
- Devices for testing blood or other body substances (except diabetes glucose monitors and their supplies)
- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to misuse

Fertility Services

"Fertility Services" means treatments and procedures to help you become pregnant.

Before starting or continuing a course of fertility Services, you may be required to pay initial and subsequent deposits toward your Cost Share for some or all of the entire course of Services, along with any past-due fertility-related Cost Share. Any unused portion of your deposit will be returned to you. When a deposit is not required, you must pay the Cost Share for the procedure, along with any past-due fertility-related Cost Share, before you can schedule a fertility procedure.

Diagnosis and treatment of infertility

For purposes of this "Diagnosis and treatment of infertility" section, "infertility" means not being able to get pregnant or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception or having a medical or other demonstrated condition that is recognized by a Plan Physician as a cause of infertility. We cover the following:

- Services for the diagnosis and treatment of infertility
- Artificial insemination

You pay the following for covered infertility Services:

- Office visits: **a $20 Copayment per visit**
- Most outpatient surgery and outpatient procedures when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or provided in any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **a $50 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a $20 Copayment per procedure**
- Outpatient imaging: **no charge**
- Outpatient laboratory: **no charge**

- Outpatient administered drugs: **no charge**
- Hospital inpatient Services (including room and board, imaging, laboratory, and other diagnostic and treatment Services, and Plan Physician Services): **a $500 Copayment per admission**

Note: Administered drugs and products are medications and products that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility.

For the following Services, refer to these sections

- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Diagnostic Services provided by Plan Providers who are not physicians, such as EKGs and EEGs (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

Fertility Services exclusions

- Reversal of surgical sterilization originally performed for family planning purposes
- Semen and eggs (and Services related to their procurement and storage)
- Assisted reproductive technology Services, such as ovum transplants, gamete intrafallopian transfer (GIFT), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT)

Fitness benefit (One Pass™)

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

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

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

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

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

Fitness benefit exclusions

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

Health Education

We cover a variety of health education counseling, programs, and materials that your personal Plan Physician or other Plan Providers provide during a visit covered under another part of this *EOC*.

We also cover a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for tobacco cessation, stress management, and chronic conditions (such as diabetes and asthma). Kaiser Permanente also offers health education counseling, programs, and materials that are not covered, and you may be required to pay a fee.

For more information about our health education counseling, programs, and materials, contact your local

Health Education Department, call Member Services or go to our website at **kp.org**.

Note: Our Health Education Department offers a comprehensive self-management workshop to help members learn the best choices in exercise, diet, monitoring, and medications to manage and control diabetes. Members may also choose to receive diabetes self-management training from a program outside our plan that is recognized by the American Diabetes Association (ADA) and approved by Medicare. Also, our Health Education Department offers education to teach kidney care and help members make informed decisions about their care.

Your Cost Share. You pay the following for these covered Services:

- Covered health education programs, which may include programs provided online and counseling over the phone: **no charge**
- Other covered individual counseling when the office visit is solely for health education: **a $20 Copayment per visit**
- Health education provided during an outpatient consultation or evaluation covered in another part of this *EOC*: **no additional Cost Share beyond the Cost Share required in that other part of this *EOC***
- Covered health education materials: **no charge**

Hearing Services

We cover the following:

- Hearing exams with an audiologist to determine the need for hearing correction: **a $20 Copayment per visit**
- Physician Specialist Visits to diagnose and treat hearing problems: **a $20 Copayment per visit**

For the following Services, refer to these sections

- Services related to the ear or hearing other than those described in this section, such as outpatient care to treat an ear infection or outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits and Your Cost Share" section)
- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Hearing Services exclusions

- Hearing aids and tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. We cover part-time or intermittent home health care in accord with Medicare guidelines. Home health care services are covered up to the number of visits and length of time that are determined to be medically necessary under the Member's home health treatment plan and no more than the limits established under Medicare guidelines, only if all of the following are true:

- You are substantially confined to your home
- Your condition requires the Services of a nurse, physical therapist, or speech therapist or continued need for an occupational therapist (home health aide Services are not covered unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide)
- A Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home
- The Services are provided inside our Service Area

Your Cost Share. We cover home health care Services at **no charge**.

For the following Services, refer to these sections

- Dialysis care (refer to "Dialysis Care")
- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy, urological, and specialized wound care supplies (refer to "Ostomy, Urological, and Specialized Wound Care Supplies")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient physical, occupational, and speech therapy visits (refer to "Outpatient Care")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Home health care exclusions

- Care in the home if the home is not a safe and effective treatment setting

Hospice Care

Hospice care is a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts of a Member experiencing the last phases of life due to a terminal illness. It also provides support to the primary caregiver and the Member's family. A Member who chooses hospice care is choosing to receive palliative care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice care benefits at any time. Note: Our plan covers hospice consultation services for a terminally ill person who hasn't elected the hospice benefit.

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

- Drugs for symptom control and pain relief
- Short-term respite care
- Home care

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

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

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

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

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

For drugs that may be covered by our plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition, you pay your Cost Share. If they're related to your terminal hospice condition, you pay Original Medicare cost-sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to "What if you're in a Medicare-certified hospice" in the "Outpatient Prescription Drugs, Supplies, and Supplements" section.

Note: If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.

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

Special note if you do not have Medicare Part A

We cover the hospice Services listed below at **no charge** only if all of the following requirements are met:

- You are not entitled to Medicare Part A
- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside our Service Area (or inside California but within 15 miles or 30 minutes from our Service Area if you live outside our Service Area, and you have been a Senior Advantage Member continuously since before January 1, 1999, at the same home address)
- The Services are provided by a licensed hospice agency that is a Plan Provider

- A Plan Physician determines that the Services are necessary for the palliation and management of your terminal illness and related conditions

If all of the above requirements are met, we cover the following hospice Services, if necessary for your hospice care:

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, and speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from a Plan Pharmacy. Certain drugs are limited to a maximum 30-day supply in any 30-day period (your Plan Pharmacy can tell you if a drug you take is one of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient Services limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling

We also cover the following hospice Services only during periods of crisis when they are Medically Necessary to achieve palliation or management of acute medical symptoms:

- Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
- Short-term inpatient Services required at a level that cannot be provided at home

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when the Services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, as amended in the most recently issued edition, *("DSM")* that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the *DSM* identifies as something other than a "mental disorder." For example, the *DSM* identifies relational problems as something other than a "mental disorder," so we do not cover services (such as couples counseling or family counseling) for relational problems.

"Mental Disorders" include the following conditions:

- Severe Mental Illness of a person of any age
- Serious Emotional Disturbance of a Child Under Age 18

In addition to the Services described in this Mental Health Services section, we also cover other Services that are Medically Necessary to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness, if the Medical Group authorizes a written referral (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Outpatient mental health Services

We cover the following Services when provided by Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license:

- Individual and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient Services for the purpose of monitoring drug therapy

Intensive psychiatric treatment programs

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

- Partial hospitalization
- Multidisciplinary treatment in an intensive outpatient or day-treatment program
- Psychiatric observation for an acute psychiatric crisis

Your Cost Share. You pay the following for these covered Services:

- Individual mental health evaluation and treatment: **a $20 Copayment per visit**

- Group mental health treatment: **a $10 Copayment per visit**
- Partial hospitalization: **no charge**
- Other intensive psychiatric treatment programs: **no charge**

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized mental health treatment, the Services are generally and customarily provided by a mental health residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group mental health evaluation and treatment
- Medical services
- Medication monitoring
- Room and board
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section)
- Discharge planning

Your Cost Share. We cover residential mental health treatment Services at **no charge**.

Inpatient psychiatric hospitalization

We cover care for acute psychiatric conditions in a Medicare-certified psychiatric hospital.

Your Cost Share. We cover inpatient psychiatric hospital Services at **a $500 Copayment per admission**.

For the following Services, refer to these sections

- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory and sleep studies (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Telehealth Visits (refer to "Telehealth Visits")

Opioid Treatment Program Services

Members with opioid use disorder (OUD) can get coverage of Services to treat OUD through an Opioid Treatment Program (OTP) which includes the following Services:

- U.S. Food and Drug Administration (FDA) approved opioid agonist and antagonist medication-assisted treatment (MAT) medications and the dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments
- Medicare Part B clinically administered drugs

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

Ostomy, Urological, and Specialized Wound Care Supplies

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

- A Plan Physician has prescribed ostomy, urological, and specialized wound care supplies for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor.

Your Cost Share: You pay the following for covered ostomy, urological, and specialized wound care supplies: **20 percent Coinsurance**.

Ostomy, urological, and specialized wound care supplies exclusions

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services

We cover the following Services at the Cost Share indicated only when part of care covered under other headings in this "Benefits and Your Cost Share" section. The Services must be prescribed by a Plan Provider:

- Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans: **no charge**
- Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds: **no charge**
- Nuclear medicine: **no charge**
- Routine preventive retinal photography screenings: **no charge**
- Routine laboratory tests to monitor the effectiveness of dialysis: **no charge**
- Hemoglobin (A1c) testing for diabetes, Low-Density Lipoprotein (LDL) testing for heart disease, International Normalized Ratio (INR) for persons with liver disease or certain blood disorders, and glucose quantitative blood tests not covered at $0 under Original Medicare: **no charge**
- All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available): **no charge**
- Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs, EEGs, and sleep studies): **no charge**
- Radiation therapy: **no charge**
- Ultraviolet light therapy treatments, including ultraviolet light therapy equipment for home use, if (1) the equipment has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section and (2) the equipment is provided inside your Home Region Service Area. (Coverage for ultraviolet light therapy equipment is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.): **no charge**

For the following Services, refer to these sections

- Outpatient imaging and laboratory Services that are Preventive Services, such as routine mammograms, bone density scans, and laboratory screening tests (refer to "Preventive Services")
- Outpatient procedures that include imaging and diagnostic Services (refer to "Outpatient surgeries and procedures")
- Services related to diagnosis and treatment of infertility, artificial insemination, or assisted reproductive technology ("ART") Services (refer to "Fertility Services")

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services exclusions

- Ultraviolet light therapy comfort, convenience, or luxury equipment or features
- Repair or replacement of ultraviolet light therapy equipment due to misuse

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, in accord with our drug formulary guidelines, subject to any applicable exclusions or limitations under this *EOC*. We cover items described in this section when prescribed as follows:

- Items prescribed by Plan Providers, within the scope of their licensure and practice
- Items prescribed by the following Non–Plan Providers unless a Plan Physician determines that the item is not Medically Necessary or the drug is for a sexual dysfunction disorder:
  - dentists if the drug is for dental care
  - Non–Plan Physicians if the Medical Group authorizes a written referral to the Non–Plan Physician (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section) and the drug, supply, or supplement is covered as part of that referral
  - Non–Plan Physicians if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described in the "Requests for Payment" section)
- The item meets the requirements of our applicable drug formulary guidelines

- You obtain the item at a Plan Pharmacy or through our mail-order service, except as otherwise described under "Certain items from Non–Plan Pharmacies" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. Refer to our Pharmacy Directory for the locations of Plan Pharmacies in your area. Plan Pharmacies can change without notice and if a pharmacy is no longer a Plan Pharmacy, you must obtain covered items from another Plan Pharmacy, except as otherwise described under "Certain items from Non–Plan Pharmacies" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section
- Your prescriber must either accept Medicare or file documentation with the Centers for Medicare & Medicaid Services showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, be aware it takes time for your prescriber to submit the necessary paperwork to be processed

In addition to our plan's Part D and medical benefits coverage, if you have Medicare Part A, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please see "What if you're in a Medicare-certified hospice" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section.

Obtaining refills by mail

Most refills are available through our mail-order service, but there are some restrictions. A Plan Pharmacy, our Pharmacy Directory, or our website at **kp.org/refill** can give you more information about obtaining refills through our mail-order service. Check with your local Plan Pharmacy if you have a question about whether your prescription can be mailed. Items available through our mail-order service are subject to change at any time without notice.

Certain items from Non–Plan Pharmacies

Generally, we cover drugs filled at a Non–Plan Pharmacy only when you aren't able to use a Plan Pharmacy. Check first with Member Services to see if there's a Plan Pharmacy nearby.

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

- The drug is related to covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section. Note: Prescription drugs prescribed and provided outside of the United States and its territories as part of covered Emergency Services or Urgent Care are covered up to a 30-day supply in a 30-day period. These drugs are not covered under Medicare Part D; therefore, payments for these drugs don't count toward reaching the Part D Catastrophic Coverage Stage
- For Medicare Part D covered drugs, the following are additional situations when a Part D drug may be covered:
  - if you are traveling within the United States and its territories but outside your Home Region Service Area and you become ill or run out of your covered Part D prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy in limited, nonroutine circumstances according to our Medicare Part D formulary guidelines
  - if you are unable to obtain a covered drug in a timely manner within your Home Region Service Area because there is no Plan Pharmacy within a reasonable driving distance that provides 24-hour service. We may not cover your prescription if a reasonable person could have purchased the drug at a Plan Pharmacy during normal business hours
  - if you are trying to fill a prescription for a drug that is not regularly stocked at an accessible Plan Pharmacy or available through our mail-order pharmacy (including high-cost drugs)
  - if you are not able to get your prescriptions from a Plan Pharmacy during a disaster

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

If you're in a Medicare-certified hospice

If you have Medicare Part A, drugs are never covered by both hospice and our plan at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, laxative, pain medication, or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

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

Medicare Part D drugs

Medicare Part D covers most outpatient prescription drugs if they are sold in the United States and approved for sale by the federal Food and Drug Administration. Our Part D formulary includes drugs that can be covered under Medicare Part D according to Medicare requirements and certain insulin administration devices (needles, syringes, alcohol swabs, and gauze). Refer to our "Medicare Part D drug formulary (2026 Comprehensive Formulary)" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section for more information about the Part D drug formulary.

Initial Coverage Stage

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

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

Cost Share for Medicare Part D drugs. Unless you reach the Catastrophic Coverage Stage in a calendar year, you will pay the following Cost Share for covered Medicare Part D drugs in the Initial Coverage Stage:

- Generic drugs: **a $10 Copayment for up to a 100-day supply**
- Brand-name and specialty drugs: **a $35 Copayment for up to a 100-day supply**
- Injectable Part D vaccines: **no charge**
- Emergency contraceptive pills: **no charge**
- Insulin-administration devices (such as needles, syringes, alcohol swabs, and gauze): **a $10 Copayment for up to a 100-day supply**

Catastrophic Coverage Stage

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Extra Help from Medicare

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

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

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

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

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

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

You or your appointed representative may need to provide the evidence to a Plan Pharmacy when obtaining covered Part D prescriptions so that we may charge you the appropriate Cost Share amount until the Centers for Medicare & Medicaid Services (CMS) updates its records to reflect your current status. Once CMS updates its records, you will no longer need to present the evidence to the Plan Pharmacy. Provide your evidence in one of the following ways so we can forward it to CMS for updating:

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

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

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

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

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

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

Medicare Prescription Payment Plan

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

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

previous month's balance, divided by the number of months left in the year.

If you disagree with the amount billed as part of this payment option, you can follow the steps described in the "Coverage Decisions. Appeals, and Complaints" section to make a complaint or appeal.

Medicare Part D drug formulary (2026 Comprehensive Formulary)

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

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

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

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

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

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

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

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

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

Preferred generic and generic drugs listed in the formulary will be subject to the generic drug Copayment or Coinsurance listed under "Cost Share for Medicare Part D drugs" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. Brand-name and nonpreferred drugs and specialty tier drugs listed in the formulary will be subject to the brand-name Copayment or Coinsurance listed under "Cost Share for Medicare Part D drugs" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. Note that sometimes a drug may appear more than once on our 2026 Comprehensive Formulary. This is because different restrictions or Cost Share may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Possible medication errors
- Drugs that may not be necessary because you take another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you take
- Unsafe amounts of opioid pain medications

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

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

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

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

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

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

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

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

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

Medicare Part D exclusions. Some kinds of prescription drugs are excluded. If you get drugs that are excluded (except for drugs described under "Outpatient drugs, supplies, and supplements not covered by Medicare"), you must pay for them yourself. If you appeal and the requested drug is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to the "Coverage Decisions, Appeals, and Complaints" section.) If a drug is not covered by Medicare Part D, any amounts you pay for that drug will not count toward reaching the Catastrophic Coverage Stage.

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

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

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

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

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

Home infusion therapy

We cover home infusion supplies and drugs at **no charge** if all of the following are true:

- Your prescription drug is on our Medicare Part D formulary
- We approved your prescription drug for home infusion therapy
- Your prescription is written by a Plan Provider and filled at a Plan home-infusion pharmacy

Outpatient drugs covered by Medicare Part B

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

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

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

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

Your Cost Share for Medicare Part B drugs. You pay the following for Medicare Part B drugs:

- Generic drugs: **a $10 Copayment for up to a 100-day supply**
- Brand-name and specialty drugs: **a $35 Copayment for up to a 100-day supply**

Certain intravenous drugs, supplies, and supplements

We cover certain self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as an intravenous or intraspinal-infusion) at **no charge** for up to a 30-day supply. In addition, we cover the supplies and equipment required for the administration of these drugs at **no charge**.

Outpatient drugs, supplies, and supplements not covered by Medicare

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

- Drugs for which a prescription is required by law. We also cover certain drugs that do not require a prescription by law if they are listed on our commercial drug formulary and prescribed by a Plan Physician
- Diaphragms, cervical caps, contraceptive rings, and contraceptive patches
- Disposable needles and syringes needed for injecting covered drugs and supplements
- Inhaler spacers needed to inhale covered drugs
- Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing
- FDA-approved medications for tobacco cessation, including over-the-counter medications when prescribed by a Plan Physician

Your Cost Share for outpatient drugs, supplies, and supplements not covered by Medicare. Your Cost Share for these items is as follows:

- Generic items (that are not described elsewhere in this *EOC*): **a $10 Copayment for up to a 100-day supply**
- Brand-name items and specialty drugs (that are not described elsewhere in this *EOC*): **a $35 Copayment for up to a 100-day supply**
- Generic drugs prescribed for the treatment of sexual dysfunction disorders: **25 percent Coinsurance for up to a 100-day supply**
- Brand drugs prescribed for the treatment of sexual dysfunction disorders: **25 percent Coinsurance for up to a 100-day supply**
- Generic drugs prescribed for the treatment of infertility: **a $10 Copayment for up to a 100-day supply**
- Brand drugs prescribed for the treatment of infertility: **a $35 Copayment for up to a 100-day supply**

- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria): **no charge for up to a 30-day supply**
- Elemental dietary enteral formula when used as a primary therapy for regional enteritis: **no charge for up to a 30-day supply**
- Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing: **no charge for up to a 100-day supply**
- Tobacco cessation drugs: **no charge**. For over-the-counter medications, we cover up to two 100-day supplies per calendar year

Note: If Charges for the drug, supply, or supplement are less than the Copayment or Coinsurance, you will pay the lesser amount.

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

Our Commercial drug formulary guidelines allow you to obtain a non-formulary prescription drug (those not listed on our drug formulary for your condition) if it would otherwise be covered by your plan, as described above, and it is Medically Necessary. If you disagree with a Health Plan determination that a non-formulary prescription drug is not covered, you may file a grievance as described in the "Coverage Decisions, Appeals, and Complaints" section.

Continuity drugs. If this *EOC* is amended to exclude a drug that we have been covering and providing to you under this *EOC*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration.

About specialty drugs. Specialty drugs are high-cost drugs that are on our specialty drug list. If your Plan Physician prescribes more than a 30-day supply for an outpatient drug, you may be able to obtain more than a 30-day supply at one time, up to the day supply limit for that drug. However, most specialty drugs are limited to a 30-day supply in any 30-day period. Your Plan Pharmacy can tell you if a drug you take is one of these drugs.

Manufacturer coupon program. For outpatient prescription drugs or items that are covered under the "Outpatient drugs, supplies, and supplements not covered by Medicare" section and obtained at a Plan Pharmacy, you may be able to use approved manufacturer coupons as payment for the Cost Share that you owe, as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire amount of your Cost Share for your prescription. Certain health plan coverages are not eligible for coupons. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at **kp.org/rxcoupons**.

For the following Services, refer to these sections

- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "Durable Medical Equipment for Home Use")
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care")
- Drugs prescribed for pain control and symptom management of the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Durable medical equipment used to administer drugs (refer to "Durable Medical Equipment for Home Use")
- Outpatient administered drugs (refer to "Outpatient Care")
- Vaccines covered by Medicare Part B (refer to "Preventive Services")

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

- The prescribing physician or dentist determines how much of a drug, supply, item, or supplement to prescribe. For purposes of day supply coverage limits, Plan Physicians determine the amount of an item that constitutes a Medically Necessary 30- or 100-day supply for you. Upon payment of the Cost Share specified in the "Outpatient prescription drugs, supplies, and supplements," you will receive the supply prescribed up to the day supply limit specified in this section or in the drug formulary for your plan (see "Commercial drug formulary" above). The maximum you may receive at one time of a covered item, is either one 30-day supply in a 30-day period or one 100-day supply in a 100-day period. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantities that exceed the day supply limit
- For sexual dysfunction drugs, the maximum you may receive at one time of episodic drugs prescribed for the treatment of sexual dysfunction disorders is eight doses in any 30-day period or up to 27 doses in any 100-day period
- The pharmacy may reduce the day supply dispensed at the Cost Share specified under "Outpatient prescription drugs, supplies, and supplements not covered by Medicare" for any drug to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan Pharmacy can tell you if a drug you take is one of these drugs)

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

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging
- Compounded products unless the drug is listed on one of our drug formularies or one of the ingredients requires a prescription by law
- Drugs prescribed to shorten the duration of the common cold
- Prescription drugs for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the prescription drug). This exclusion does not apply to:
  - ♦ insulin
  - ♦ over-the-counter tobacco cessation drugs and contraceptive drugs
  - ♦ an entire class of prescription drugs when one drug within that class becomes available over-the-counter
- All drugs, supplies, and supplements related to covered assisted reproductive technology (ART) Services
- Drugs when prescribed solely for the purposes of losing weight, except when Medically Necessary for the treatment of morbid obesity. We may require Members who are prescribed drugs for morbid obesity to be enrolled in a covered comprehensive weight loss program, for a reasonable period of time prior to or concurrent with receiving the prescription drug

Preventive Services

We cover a variety of Preventive Services in accord with Medicare guidelines. The list of Preventive Services is subject to change by the Centers for Medicare & Medicaid Services. These Preventive Services are subject to all coverage requirements described in this "Benefits and Your Cost Share" section and all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. If you have questions about Preventive Services, please call Member Services.

Note: If you receive any other covered Services that are not Preventive Services during or subsequent to a visit that includes Preventive Services on the list, you will pay the applicable Cost Share for those other Services. For example, if laboratory tests or imaging Services ordered during a preventive office visit are not Preventive Services, you will pay the applicable Cost Share for those Services.

Your Cost Share. You pay the following for covered Preventive Services:

- Abdominal aortic aneurysm screening: **no charge**
- Annual Wellness visit: **no charge**
- Bone mass measurement: **no charge**
- Breast cancer screening (mammograms): **no charge**
- Cardiovascular disease risk reduction visit (therapy for cardiovascular disease): **no charge**
- Cardiovascular disease screening tests: **no charge**
- Cervical and vaginal cancer screening: **no charge**
- Colorectal cancer screening, including flexible sigmoidoscopies, colonoscopies, and fecal occult blood tests: **no charge**
- Depression screening: **no charge**

- Diabetes screening, including fasting glucose tests: **no charge**
- Diabetes self-management training: **no charge**
- Glaucoma screening: **no charge**
- HIV screening: **no charge**
- Immunizations (including the vaccine) covered by Medicare Part B such as Hepatitis B, flu/influenza, pneumococcal, and COVID-19 vaccines that are administered to you in a Plan Medical Office: **no charge**
- Lung cancer screening with low dose computed tomography (LDCT): **no charge**
- Medical nutrition therapy for kidney disease and diabetes: **no charge**
- Medicare diabetes prevention program (MDPP): **no charge**
- Obesity screening and therapy to promote sustained weight loss: **no charge**
- Pre-exposure prophylaxis (PrEP) for HIV prevention: **no charge**
- Prostate cancer screening exams, including digital rectal exams and Prostate Specific Antigen (PSA) tests: **no charge**
- Screening for Hepatitis C Virus infection: **no charge**
- Screening and counseling to reduce alcohol misuse: **no charge**
- Screening for sexually transmitted infections (STIs) and counseling to prevent STIs: **no charge**
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use): **no charge**
- Welcome to Medicare preventive visit: **no charge**

Prosthetic and Orthotic Devices

Prosthetic and orthotic devices coverage rules

We cover the prosthetic and orthotic devices specified in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage includes fitting and adjustment of these devices, their repair or replacement, and Services to determine whether you need a prosthetic or orthotic device. If we cover a replacement device, then you pay the Cost Share that you would pay for obtaining that device.

Base prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the items described in this "Base prosthetic and orthotic devices" section.

Internally implanted devices. We cover prosthetic and orthotic devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, in accord with Medicare guidelines, if they are implanted during a surgery that we are covering under another section of this "Benefits and Your Cost Share" section. We cover these devices at **no charge**.

External devices. We cover the following external prosthetic and orthotic devices at **20 percent Coinsurance**:

- Prosthetics and orthotics in accord with Medicare guidelines. These include, but are not limited to, braces, prosthetic shoes, artificial limbs, and therapeutic footwear for severe diabetes-related foot disease in accord with Medicare guidelines
- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- After Medically Necessary removal of all or part of a breast, prosthesis including custom-made prostheses when Medically Necessary
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Enteral pump and supplies
- Tracheostomy tube and supplies

- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

Other covered prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the following items described in this "Other covered prosthetic and orthotic devices" section:

- Prosthetic devices required to replace all or part of an organ or extremity, in accord with Medicare guidelines
- Vacuum erection device for sexual dysfunction
- Certain surgical boots following surgery when provided during an outpatient visit
- Orthotic devices required to support or correct a defective body part, in accord with Medicare guidelines

Your Cost Share. You pay the following for other covered prosthetic and orthotic devices: **20 percent Coinsurance**. For internally implanted prosthetic and orthotic devices, you pay the Cost Share for the procedure to implant the device. For example, see "Outpatient Care" in this "Benefits and Your Cost Share" section for the Cost Share that applies for outpatient surgery.

For the following Services, refer to these sections

- Eyeglasses and contact lenses, including contact lenses to treat aniridia or aphakia (refer to "Vision Services")
- Eyewear following cataract surgery (refer to "Vision Services")
- Hearing aids other than internally implanted devices described in this section (refer to "Hearing Services")
- Injectable implants (refer to "Administered drugs and products" under "Outpatient Care")

Prosthetic and orthotic devices exclusions

- Dental appliances
- Nonrigid supplies not covered by Medicare, such as elastic stockings and wigs, except as otherwise described above in this "Prosthetic and Orthotic Devices" section and the "Ostomy, Urological, and Specialized Wound Care Supplies" section
- Comfort, convenience, or luxury equipment or features
- Repair or replacement of device due to misuse
- Shoes, shoe inserts, arch supports, or any other footwear, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications
- Prosthetic and orthotic devices not intended for maintaining normal activities of daily living (including devices intended to provide additional support for recreational or sports activities)
- Nonconventional intraocular lenses (IOLs) following cataract surgery (for example, presbyopia-correcting IOLs). You may request and we may provide insertion of presbyopia-correcting IOLs or astigmatism-correcting IOLs following cataract surgery in lieu of conventional IOLs. However, you must pay the difference between Charges for nonconventional IOLs and associated services and Charges for insertion of conventional IOLs following cataract surgery

Reconstructive Surgery

We cover the following reconstructive surgery Services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Plan Physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible
- Following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

Your Cost Share. You pay the following for covered reconstructive surgery Services:

- Outpatient surgery and outpatient procedures when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **a $50 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a $20 Copayment per procedure**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this "Benefits and Your Cost Share" section (for example, radiology procedures that do not require a licensed staff

member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

- Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services): **a $500 Copayment per admission**

For the following Services, refer to these sections

- Office visits not described in this "Reconstructive Surgery" section (refer to "Outpatient Care")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Telehealth Visits (refer to "Telehealth Visits")

Reconstructive surgery exclusions

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance

Religious Nonmedical Health Care Institution Services

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

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

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

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

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

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

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

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

Services Associated with Clinical Trials

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

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

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

with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

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

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

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

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

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

Services associated with clinical trials exclusions

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

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

Skilled Nursing Facility Care

Inside our Service Area, we cover up to 100 days per benefit period of skilled inpatient Services in a Plan Skilled Nursing Facility and in accord with Medicare guidelines. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care (defined in accord with Medicare guidelines). A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required. Note: If your Cost Share changes during a benefit period, you will continue to pay the previous Cost Share amount until a new benefit period begins.

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment in accord with our prior authorization procedure if Skilled Nursing Facilities ordinarily furnish the equipment (refer to "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)
- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Whole blood, red blood cells, plasma, platelets, and their administration
- Medical supplies
- Physical, occupational, and speech therapy in accord with Medicare guidelines
- Respiratory therapy

Non–Plan Skilled Nursing Facility care

Generally, you get Skilled Nursing Facility care from Plan Facilities. Under certain conditions listed below, you may be able to receive covered care from a non–Plan facility, if the facility accepts our plan's amounts for payment.

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides Skilled Nursing Facility care)
- A Skilled Nursing Facility where your Spouse is living at the time you leave the hospital

Your Cost Share. We cover these Skilled Nursing Facility Services at **no charge**.

For the following Services, refer to these sections

- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

Substance Use Disorder Treatment

We cover Services specified in this "Substance Use Disorder Treatment" section only when the Services are for the preventive, diagnosis, or treatment of Substance Use Disorders. A "Substance Use Disorder" is a condition identified as a "substance use disorder" in the most recently issued edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM").

Outpatient substance use disorder treatment

We cover the following Services for treatment of substance use disorders:

- Day-treatment programs
- Individual and group substance use disorder counseling by a qualified clinician, including a licensed marriage and family therapist (LMFT)
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms

Your Cost Share. You pay the following for these covered Services:

- Individual substance use disorder evaluation and treatment: **a $20 Copayment per visit**
- Group substance use disorder treatment: **a $5 Copayment per visit**
- Intensive outpatient and day-treatment programs: **a $5 Copayment per day**

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized substance use disorder treatment, the Services are generally and customarily provided by a substance use disorder residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group substance use disorder counseling
- Medical services
- Medication monitoring
- Room and board
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section)
- Discharge planning

Your Cost Share. We cover residential substance use disorder treatment Services at **a $100 Copayment per admission**.

Inpatient detoxification

We cover hospitalization in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Your Cost Share. We cover inpatient detoxification Services at **a $500 Copayment per admission**.

For the following Services, refer to these sections

- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient self-administered drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Telehealth Visits (refer to "Telehealth Visits")

Telehealth Visits

Telehealth Visits between you and your provider are intended to make it more convenient for you to receive covered Services, when a Plan Provider determines it is medically appropriate for your medical condition. You have the option of receiving these services either through

an in-person visit or via telehealth. You may receive covered Services via Telehealth Visits, when available and if the Services would have been covered under this *EOC* if provided in person. If you choose to receive Services via telehealth, then you must use a Plan Provider that currently offers the service via telehealth. We offer the following telehealth Services:

- Telehealth Services for monthly End-Stage Renal Disease--related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the Member's home
- Telehealth Services to diagnose, evaluate or treat symptoms of a stroke, regardless of your location
- Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location
- Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:
  - you have an in-person visit within 6 months prior to your first telehealth visit
  - you have an in-person visit every 12 months while getting these telehealth services
  - exceptions can be made to the above for certain circumstances
- Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers
- Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if:
  - you're not a new patient and
  - the check-in isn't related to an office visit in the past 7 days and
  - the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment
- Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if:
  - you're not a new patient and
  - the evaluation isn't related to an office visit in the past 7 days and
  - the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
- Consultation your doctor has with other doctors by phone, internet, or electronic health record

Your Cost Share. You pay the following types for Telehealth Visits with Primary Care Physicians, Non-Physician Specialists, and Physician Specialists:

- Interactive video visits: **no charge**
- Scheduled telephone visits: **no charge**

Transplant Services

We cover transplants of organs, tissue, or bone marrow in accord with Medicare guidelines and if the Medical Group provides a written referral for care to a transplant facility as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

After the referral to a transplant facility, the following applies:

- If either the Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover Services you receive before that determination is made
- Health Plan, Plan Hospitals, the Medical Group, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with our guidelines for Services for living transplant donors, we provide certain donation-related Services for a donor, or an individual identified by the Medical Group as a potential donor, whether or not the donor is a Member. These Services must be directly related to a covered transplant for you, which may include certain Services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Please call Member Services for questions about donor Services

Your Cost Share. For covered transplant Services that you receive, you will pay the **Cost Share you would pay if the Services were not related to a transplant**. For example, see "Hospital Inpatient Services" in this "Benefits and Your Cost Share" section for the Cost Share that applies for hospital inpatient Services.

We provide or pay for donation-related Services for actual or potential donors (whether or not they are Members) in accord with our guidelines for donor Services at **no charge**.

For the following Services, refer to these sections

- Dental Services that are Medically Necessary to prepare for a transplant (refer to "Dental Services")

- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Vision Services

We cover the following:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses: **a $20 Copayment per visit**
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **a $20 Copayment per visit**
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **a $20 Copayment per visit**

Optical Services

We cover the Services described in this "Optical Services" section when received from Plan Medical Offices or Plan Optical Sales Offices.

The date we provide an Allowance toward (or otherwise cover) an item described in this "Optical Services" section is the date on which you order the item. For example, if we last provided an Allowance toward an item you ordered on May 1, 2024, and if we provide an Allowance not more than once every 24 months for that type of item, then we would not provide another Allowance toward that type of item until on or after May 1, 2026. You can use the Allowances under this "Optical Services" section only when you first order an item. If you use part but not all of an Allowance when you first order an item, you cannot use the rest of that Allowance later.

Eyeglasses and contact lenses following cataract surgery

We cover at **no charge** one pair of eyeglasses or contact lenses (including fitting or dispensing) following each cataract surgery that includes insertion of an intraocular lens at Plan Medical Offices or Plan Optical Sales Offices when prescribed by a physician or optometrist. When multiple cataract surgeries are needed, and you do not obtain eyeglasses or contact lenses between procedures, we will only cover one pair of eyeglasses or contact lenses after any surgery. If the eyewear you purchase costs more than what Medicare covers for someone who has Original Medicare (also known as "Fee-for-Service Medicare"), you pay the difference.

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist: **no charge**
- In accord with Medicare guidelines, we cover corrective lenses (including contact lens fitting and dispensing) and frames (and replacements) for Members who are aphakic (for example, who have had a cataract removed but don't have an implanted intraocular lens (IOL) or who have congenital absence of the lens): **no charge**
- For other specialty contact lenses that will provide a significant improvement in your vision not obtainable with eyeglass lenses, we cover either one pair of contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses (up to six months, including fitting and dispensing) in any 24 months at **no charge**

Eyeglasses and contact lenses

We provide a single **$150 allowance** toward the purchase price of any or all of the following not more than once every 24 months when a physician or optometrist prescribes an eyeglass lens (for eyeglass lenses and frames) or contact lens (for contact lenses):

- Eyeglass lenses when a Plan Provider puts the lenses into a frame
  - ♦ we cover a clear balance lens when only one eye needs correction
  - ♦ we cover tinted lenses when Medically Necessary to treat macular degeneration or retinitis pigmentosa
- Eyeglass frames when a Plan Provider puts two lenses (at least one of which must have refractive value) into the frame
- Contact lenses, fitting, and dispensing

We will not provide the Allowance if we have provided an Allowance toward (or otherwise covered) eyeglass lenses or frames within the previous 24 months.

Replacement lenses

If you have a change in prescription of at least .50 diopter in one or both eyes within 12 months of the initial point of sale of an eyeglass lens or contact lens that we provided an Allowance toward (or otherwise

covered) we'll provide an Allowance toward the purchase price of a replacement item of the same type (eyeglass lens, or contact lens, fitting, and dispensing) for the eye that had the .50 diopter change. The Allowance toward one of these replacement lenses is $30 for a single vision eyeglass lens or for a contact lens (including fitting and dispensing) and $45 for a multifocal or lenticular eyeglass lens.

For the following Services, refer to these sections

- Services related to the eye or vision other than Services covered under this "Vision Services" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits and Your Cost Share" section)

Vision Services exclusions

- Eyeglass or contact lens adornment, such as engraving, faceting, or jeweling
- Items that do not require a prescription by law (other than eyeglass frames), such as eyeglass holders, eyeglass cases, and repair kits
- Lenses and sunglasses without refractive value, except as described in this "Vision Services" section
- Low vision devices
- Replacement of lost, broken, or damaged contact lenses, eyeglass lenses, and frames

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this *EOC* regardless of whether the services are within the scope of a provider's license or certificate. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in this *EOC*. These exclusions or limitations do not apply to Services that are Medically Necessary to treat Severe Mental Illness or Serious Emotional Disturbance of a Child Under Age 18.

Certain exams and Services

Routine physical exams and other Services that are not Medically Necessary, such as when required (1) for obtaining or maintaining employment or participation in employee programs, (2) for insurance, credentialing or licensing, (3) for travel, or (4) by court order or for parole or probation.

Chiropractic Services

Chiropractic Services and the Services of a chiropractor, except for manual manipulation of the spine as described under "Outpatient Care" in the "Benefits and Your Cost Share" section or unless you have coverage for supplemental chiropractic Services as described in an amendment to this *EOC*.

Cosmetic Services

Services that are intended primarily to change or maintain your appearance, including cosmetic surgery (surgery that is performed to alter or reshape normal structures of the body in order to improve appearance), except that this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "Benefits and Your Cost Share" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "Benefits and Your Cost Share" section: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after removal of all or part of a breast or lumpectomy, and prostheses to replace all or part of an external facial body part

Custodial care

Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion doesn't apply to assistance with activities of daily living that is provided as part of covered hospice for Members who do not have Part A, Skilled Nursing Facility, or hospital inpatient care.

Dental care

Dental care and dental X-rays, such as dental Services following accidental injury to teeth, dental appliances, dental implants, orthodontia, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment, except for Services covered in accord with Medicare guidelines or under "Dental Services" in the "Benefits and Your Cost Share" section.

Disposable supplies

Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies.

This exclusion does not apply to disposable supplies covered in accord with Medicare guidelines or under "Durable Medical Equipment ("DME") for Home Use," "Home Health Care," "Hospice Care," "Ostomy, Urological, and Wound Care Supplies," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Prosthetic and Orthotic Devices" in the "Benefits and Your Cost Share" section.

Experimental or investigational Services

A Service is experimental or investigational if we, in consultation with the Medical Group, determine that one of the following is true:

- Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients)
- It requires government approval that has not been obtained when the Service is to be provided

Hair loss or growth treatment

Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Durable Medical Equipment ("DME") for Home Use," "Home Health Care," and "Hospice Care" in the "Benefits and Your Cost Share" section.

Items and services that are not health care items and services

For example, we do not cover:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services for the purpose of increasing academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play, or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy, except when ordered as part of a physical therapy program in accord with Medicare guidelines

Items and services to correct refractive defects of the eye

Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism.

Massage therapy

Massage therapy, and services of massage therapists.

Oral nutrition and weight loss aids

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

This exclusion does not apply to any of the following:

- Amino acid–modified products and elemental dietary enteral formula covered under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section
- Enteral formula covered under "Prosthetic and Orthotic Devices" in the "Benefits and Your Cost Share" section

Residential care

Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a Skilled Nursing Facility, inpatient respite care covered in the "Hospice Care" section for Members who do not have Part A, or residential treatment program Services covered in the "Substance Use Disorder Treatment" and "Mental Health Services" sections.

Routine foot care items and services

Routine foot care items and services, except for Medically Necessary Services covered in accord with Medicare guidelines.

Services not approved by the federal Food and Drug Administration

Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other Services that by law require federal Food and Drug Administration ("FDA") approval in order to be sold in the U.S., but are not approved by the FDA. This exclusion applies to Services provided anywhere, even outside the U.S., unless the Services are covered under the "Emergency Services and Urgent Care" section.

Services and items not covered by Medicare

Services and items that are not covered by Medicare, including services and items that aren't reasonable and necessary, according to the standards of the Original Medicare plan, unless these Services are otherwise listed in this *EOC* as a covered Service.

Services performed by unlicensed people

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

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services we would otherwise cover to treat complications of the noncovered Service or if covered in accord with Medicare guidelines. For example, if you have a noncovered cosmetic surgery, we would not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and we would cover any Services that we would otherwise cover to treat that complication.

Surrogacy

Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. Refer to "Surrogacy Arrangements" under "Reductions" in this "Exclusions, Limitations, Coordination of Benefits, and Reductions" section for information about your obligations to us in connection with a Surrogacy Arrangement, including your obligations to reimburse us for any Services we cover and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.

Travel and lodging expenses

Travel and lodging expenses, except as described in our Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at **kp.org/specialty-care/travel-reimbursements** or by calling Member Services.

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC*, such as a major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor dispute. Under these circumstances, if you have an Emergency Medical Condition, call 911 or go to the nearest Emergency Department as described under "Emergency Services" in the "Emergency Services and Urgent Care" section, and we will provide coverage and reimbursement as described in that section.

Additional limitations that apply only to a particular benefit are listed in the description of that benefit in this *EOC*.

Coordination of Benefits

If you have other medical or dental coverage, it is important to use your other coverage in combination with your coverage as a Senior Advantage Member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

You must tell us if you have other health care coverage, and let us know whenever there are any changes in your additional coverage. The types of additional coverage that you might have include the following:

- Coverage that you have from an employer's group health care coverage for employees or retirees, either through yourself or your spouse
- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program
- Coverage you have for an accident where no-fault insurance or liability insurance is involved
- Coverage you have through Medicaid
- Coverage you have through the "TRICARE for Life" program (veteran's benefits)
- Coverage you have for dental insurance or prescription drugs

- "Continuation coverage" you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions)

When you have additional health care coverage, how we coordinate your benefits as a Senior Advantage Member with your benefits from your other coverage depends on your situation. With coordination of benefits, you will often get your care as usual from Plan Providers, and the other coverage you have will simply help pay for the care you receive. In other situations, such as benefits that we don't cover, you may get your care outside of our plan directly through your other coverage.

In general, the coverage that pays its share of your bills first is called the "primary payer." Then the other company or companies that are involved (called the "secondary payers") each pay their share of what is left of your bills. Often your other coverage will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this payment to us. When you have additional coverage, whether we pay first or second, or at all, depends on what type or types of additional coverage you have and the rules that apply to your situation. Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have End-Stage Renal Disease, or how many employees are covered by an employer's group plan.

If you have additional health coverage, please call Member Services to find out which rules apply to your situation, and how payment will be handled.

Reductions

Employer responsibility

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

Government agency responsibility

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

Injuries or illnesses alleged to be caused by third parties

Third parties who cause you injury or illness (and/or their insurance companies) usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue these primary payments. If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered Services, you must ensure we receive reimbursement for those Services. Note: This "Injuries or illnesses alleged to be caused by third parties" section does not affect your obligation to pay your Cost Share for these Services.

To the extent permitted or required by law, we shall be subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain against a third party that results in any settlement proceeds or judgment, from other types of coverage that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, workers' compensation, personal injury, medical payments and all other first party types. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether you are made whole and regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred. We are not required to pay attorney fees or costs to any attorney hired by you to pursue your damages claim. If you reimburse us without the need for legal action, we will allow a procurement cost discount. If we have to pursue legal action to enforce its interest, there will be no procurement discount.

Within 30 days after submitting or filing a claim or legal action against a third party, you must send written notice of the claim or legal action to:

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

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

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

Surrogacy Arrangements

If you enter into a Surrogacy Arrangement and you or any other payee are entitled to receive monetary compensation under the Surrogacy Arrangement, you must reimburse us for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services") to the maximum extent allowed under California Civil Code Section 3040. Note: This "Surrogacy Arrangements" section does not affect your obligation to pay your Cost Share for these Services. After you surrender a baby to the legal parents, you are not obligated to reimburse us for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and phone numbers of the other parties to the arrangement
- Names, addresses, and phone numbers of any escrow agent or trustee
- Names, addresses, and phone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receive, including names, addresses, and phone numbers for any health insurance that will cover Services that the baby (or babies) receive
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

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

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy Arrangements" section and to satisfy those rights. You may not agree to waive, release, or reduce our rights under this "Surrogacy Arrangements" section without our prior, written consent.

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

If you have questions about your obligations under this provision, please call Member Services.

U.S. Department of Veterans Affairs

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

Workers' compensation or employer's liability benefits

Workers' compensation usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue primary payments under workers' compensation or employer's liability law. You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered Services from the following sources:

- From any source providing a Financial Benefit or from whom a Financial Benefit is due
- From you, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law

Requests for Payment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Rights and Responsibilities

Our plan must honor your rights and cultural sensitivities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If you think you aren't getting your medical care or drugs within a reasonable amount of time, "How to make a complaint about quality of care, waiting times, customer service, or other concerns" in the "Coverage Decisions, Appeals, and Complaints" section tells what you can do.

We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you or someone you have given legal power to make decisions for you first

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

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

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

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

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

We must give you information about our plan, our Plan Providers, and your covered services

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

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

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

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

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

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

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

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

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

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

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

How to set up an advance directive to give instructions:

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

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

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

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

If your instructions aren't followed

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

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

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

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

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

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

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

How to get more information about your rights

Get more information about your rights from these places:

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

Information about new technology assessments

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

You can make suggestions about rights and responsibilities

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

Your responsibilities as a Member of our plan

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

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

Coverage Decisions, Appeals, and Complaints

What to Do if You Have a Problem or Concern

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

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

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

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

Hospice care

If you have Medicare Part A, your hospice care is covered by Original Medicare and it is not covered under this *EOC*. Therefore, any complaints related to the coverage of hospice care must be resolved directly with Medicare and not through any complaint or appeal procedure discussed in this *EOC*. Medicare complaint and appeal procedures are described in the Medicare handbook Medicare & You, which is available from your local Social Security office, at **https://www.Medicare.gov**, or by calling toll free **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**). If you do not have Medicare Part A, Original Medicare does not cover hospice care. Instead, we will provide hospice care, and any complaints related to hospice care are subject to this "Coverage Decisions, Appeals, and Complaints" section.

Legal terms

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

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

Where To Get More Information and Personalized Help

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

State Health Insurance Assistance Program (SHIP)

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

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

Medicare

You can also contact Medicare for help.

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

Which Process to Use for Your Problem

Is your problem or concern about your benefits or coverage?

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

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

A Guide to Coverage Decisions and Appeals

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

Asking for coverage decisions before you get services

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

cover a particular medical service or refuses to provide medical care you think you need.

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

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

Making an appeal

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

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

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

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

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

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

Get help asking for a coverage decision or making an appeal

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

- **Call Member Services**
- **Get free help** from your State Health Insurance Assistance Program
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services and ask for the Appointment of Representative form. (The form is also available at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **kp.org**)
  - for medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2
  - for Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal
  - if you want a friend, relative, or other person to be your representative, call Member Services and ask for the Appointment of Representative form. (The form is also available at **https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **kp.org**.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form
  - we can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get

the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal

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

Rules and deadlines for different situations

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

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

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

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

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

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

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

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

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

How to ask for a coverage decision

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

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

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

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

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

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

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

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

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

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

For standard coverage decisions, we use the standard deadlines.

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

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

For fast coverage decisions, we use an expedited timeframe.

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

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

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

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

How to make a Level 1 appeal

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

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

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

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in

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

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

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

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

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

Deadlines for a fast appeal

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

Deadlines for a standard appeal

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

The Level 2 appeal process

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

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

Step 1: The independent review organization reviews your appeal

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

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

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

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

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

Step 2: The independent review organization gives you its answer

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

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

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

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

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

The "Requests for Payment" section describes when you may need to ask for reimbursement or to pay a bill you

got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

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

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

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

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

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

Part D Drugs: How to Ask for a Coverage Decision or Make an Appeal

What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

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

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

Part D coverage decisions and appeals

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

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

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

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

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

Asking for an exception

- Asking for coverage of a drug that's not on the Drug List is a formulary exception

- Asking for removal of a restriction on coverage for a drug is a **formulary exception**
- Asking to pay a lower price for a covered non-preferred drug is a **tiering exception**

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

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

- **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay your Cost Share, which will vary depending on your plan. You can't ask for an exception to the Cost Share we require you to pay for the drug
- **Removing a restriction for a covered drug**. "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the Cost Share we require you to pay for the drug
- **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you pay as your share of the cost of the drug
  - ♦ if our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s)
  - ♦ if the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition
  - ♦ if the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition
  - ♦ if the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition
  - ♦ you can't ask us to change the cost-sharing tier for any drug in Tier 5 (specialty-tier drugs)
  - ♦ if we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount

Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

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

We can say yes or no to your request

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

How to ask for a coverage decision, including an exception

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

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

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

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

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

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

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website **kp.org**. The "Phone Numbers and Resources" section has contact information. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

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

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

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

Deadlines for a fast coverage decision

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

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

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

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

- We must give you our answer **within 14 calendar days** after we get your request
  - if we don't meet this deadline, we're required to send your request to Level 2 of the appeals

process, where it will be reviewed by an independent review organization

- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within 14 calendar days after we get your request
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal

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

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

How to make a Level 1 appeal

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

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

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

- If you're appealing a decision we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in "How to ask for a coverage decision, including a Part D exception"

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

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

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

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

Deadlines for a fast appeal

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

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

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so
  - ♦ if we don't give you a decision within 7 calendar days, we're required to send your request to Level

2 of the appeals process, where it will be reviewed by an independent review organization. "How to make a Level 2 appeal" explains the Level 2 appeal process

- **If our answer is yes to part or all of what you asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision

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

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

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

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

How to make a Level 2 appeal

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

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

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

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

Step 2: The independent review organization reviews your appeal

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

Deadlines for fast appeal

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

Deadlines for standard appeal

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

Step 3: The independent review organization gives you its answer

For fast appeals:

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

independent review organization **within 24 hours** after we get the decision from the independent review organization

For standard appeals:

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

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

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

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

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

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

How to Ask Us to Cover a Longer Inpatient Hospital Stay if You Think You're Being Discharged Too Soon

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

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

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

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

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

- **Read this notice carefully and ask questions if you don't understand it.** It tells you:
  - your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them
  - your right to be involved in any decisions about your hospital stay
  - where to report any concerns you have about the quality of your hospital care
  - your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so we'll cover your hospital care for a longer time

- **You'll be asked to sign the written notice to show that you got it and understand your rights**
  - you or someone who is acting on your behalf will be asked to sign the notice
  - signing the notice shows only that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date
- **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it
  - if you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged
  - to look at a copy of this notice in advance, call Member Services or **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**. You can also get the notice online at **www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im**

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

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

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

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

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

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

How can you contact this organization?

- The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in the "Phone Numbers and Resources" section

Act quickly

- To make your appeal, you must contact the Quality Improvement Organization **before** you leave the hospital and **no later than midnight the day of your discharge**
  - **if you meet this deadline**, you can stay in the hospital after your discharge date without paying for it while you wait to get the decision from the Quality Improvement Organization
  - **if you don't meet this deadline, contact us**. If you decide to stay in the hospital after your planned discharge date, you may have to pay the costs for hospital care you get after your planned discharge date

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

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

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

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them

- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

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

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

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

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

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

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

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

If the independent review organization says yes:

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

If the independent review organization says no:

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

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

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

How to Ask Us to Keep Covering Certain Medical Services if You Think Your Coverage Is Ending Too Soon

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

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

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

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

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

- **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
  - the date when we'll stop covering the care for you
  - how to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time
- **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got.** Signing the notice shows *only* that you have got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care

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

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

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

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

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

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

How can you contact this organization?

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

Act quickly

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

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

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you or your representative why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want

- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them
- By the end of the day the reviewers tell us of your appeal, you'll get the *Detailed Explanation of Non-Coverage* from us that explains in detail our reasons for ending our coverage for your services.

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

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

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

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

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

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

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

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

What happens if the independent review organization says yes?

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

What happens if the independent review organization says no?

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

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

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

Taking Your Appeal to Levels 3, 4, and 5

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

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

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

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

Level 3 appeal

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

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

Level 4 appeal

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

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

Level 5 appeal

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

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

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

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

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

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

Level 3 appeal

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

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision

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

Level 4 appeal

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

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

Level 5 appeal

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

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

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

What kinds of problems are handled by the complaint process?

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

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

How to make a complaint

- A **complaint** is also called a **grievance**
- **Making a complaint** is called **filing a grievance**

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

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

- **Calling Member Services is usually the first step**. If there's anything else you need to do, Member Services will let you know
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us**. If you put your complaint in writing, we'll respond to your complaint in writing
- **If you have a complaint, we'll try to resolve your complaint over the phone**. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. Your grievance must explain your concern, such as why you're dissatisfied with the services you received. Go to the "Phone Numbers and Resources" section for whom you should contact if you have a complaint
  - you must submit your grievance to us (orally or in writing) within 60 calendar days of the event or incident. We must address your grievance as quickly as your health requires, but no later than 30 calendar days after receiving your complaint. We may extend the time frame to make our decision by up to 14 calendar days if you ask for an extension, or if we justify a need for additional information and the delay is in your best interest
  - you can file a fast grievance about our decision not to expedite a coverage decision or appeal for medical care or items, or if we extend the time we need to make a decision about a coverage decision or appeal for medical care or items. We must respond to your fast grievance **within 24 hours**
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about

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

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

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

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

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

You can also tell Medicare about your complaint

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

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (1-866-444-3272)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Binding Arbitration

For all claims subject to this "Binding Arbitration" section, both Claimants and Respondents give up the right to a jury or court trial and accept the use of binding arbitration. Insofar as this "Binding Arbitration" section applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this *EOC*. Such retroactive application shall be binding only on the Kaiser Permanente Parties.

Scope of arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *EOC* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. ("Health Plan"), including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of the legal theories upon which the claim is asserted
- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- Governing law does not prevent the use of binding arbitration to resolve the claim

Members enrolled under this *EOC* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeal procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

As referred to in this "Binding Arbitration" section, "Member Parties" include:

- A Member
- A Member's heir, relative, or personal representative
- Any person claiming that a duty to them arises from a Member's relationship to one or more Kaiser Permanente Parties

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any Southern California Permanente Medical Group or The Permanente Medical Group physician
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties
- Any employee or agent of any of the foregoing

"Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts a claim as described above. "Respondent" refers to a Member Party or a Kaiser Permanente Party against whom a claim is asserted.

Rules of Procedure

Arbitrations shall be conducted according to the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of Procedure") developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from Member Services.

Initiating arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and phone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include in the Demand for Arbitration all claims against Respondents that are based on the same incident, transaction, or related circumstances.

Serving Demand for Arbitration

Health Plan, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

Kaiser Foundation Health Plan, Inc.
Legal Department, Professional & Public Liability
393 E. Walnut St.
Pasadena, CA 91188

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

Filing fee

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

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling Member Services.

Number of arbitrators

The number of arbitrators may affect the Claimants' responsibility for paying the neutral arbitrator's fees and expenses (see the Rules of Procedure).

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing after a dispute has arisen and a request for binding arbitration has been submitted that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of arbitrators' fees and expenses

Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the Rules of Procedure. In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs

Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this "Binding Arbitration" section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

General provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondent served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for non-economic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration" section. In accord with the rule

that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration" section shall not be denied, stayed, or otherwise impeded because a dispute between a Member Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with another party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2027, your last minute of coverage was at 11:59 p.m. on December 31, 2026). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *EOC* after your membership terminates, except:

- As provided under "Payments after Termination" in this "Termination of Membership" section
- If you are receiving covered Services as an acute care hospital inpatient on the termination date, we will continue to cover those hospital Services (but not physician Services or any other Services) until you are discharged

Until your membership terminates, you remain a Senior Advantage Member and must continue to receive your medical care from us, except as described in the "Emergency Services and Urgent Care" section about Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care and the "Benefits and Your Cost Share" section about out-of-area dialysis care.

Note: If you enroll in another Medicare Health Plan or a prescription drug plan, your Senior Advantage membership will terminate as described under "Disenrolling from Senior Advantage" in this "Termination of Membership" section.

Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section your Group will notify you of the date that your membership will end. Your membership termination date is the first day you are not covered. For example, if your termination date is January 1, 2027, your last minute of coverage was at 11:59 p.m. on December 31, 2026.

Also, we will terminate your Senior Advantage membership on the last day of the month if you:

- Are temporarily absent from our Service Area for more than six months in a row
- Permanently move from our Service Area
- No longer have Medicare Part B
- Enroll in another Medicare Health Plan (for example, a Medicare Advantage Plan or a Medicare prescription drug plan). The Centers for Medicare & Medicaid Services will automatically terminate your Senior Advantage membership when your enrollment in the other plan becomes effective
- Are not a U.S. citizen or lawfully present in the United States. The Centers for Medicare & Medicaid Services will notify us if you are not eligible to remain a Member on this basis. We must disenroll you if you do not meet this requirement

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

Note: If you lose eligibility for Senior Advantage due to any of these circumstances, you may be eligible to transfer your membership to another Kaiser Permanente plan offered by your Group. Please contact your Group for information.

Termination of *Agreement*

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. Your Group is required to notify Subscribers in writing if its *Agreement* with us terminates.

Disenrolling from Senior Advantage

You may terminate (disenroll from) your Senior Advantage membership at any time. However, before you request disenrollment, please check with your Group to determine if you are able to continue your Group membership.

If you request disenrollment during your Group's open enrollment, your disenrollment effective date is determined by the date your written request is received

by us and the date your Group coverage ends. The effective date will not be earlier than the first day of the following month after we receive your written request, and no later than three months after we receive your request.

If you request disenrollment at a time other than your Group's open enrollment, your disenrollment effective date will be the first day of the month following our receipt of your disenrollment request.

You may request disenrollment by:

- Calling toll free **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**
- Sending written notice to the following address:
  Kaiser Permanente
  Medicare Unit
  P.O. Box 232400
  San Diego, CA 92193-2400

Other Medicare Health Plans. If you want to enroll in another Medicare Health Plan or a Medicare prescription drug plan, you should first confirm with the other plan and your Group that you're able to enroll. Your new plan or your Group will tell you the date when your membership in the new plan begins and your Senior Advantage membership will end on that same day (your disenrollment date).

The Centers for Medicare & Medicaid Services will let us know if you enroll in another Medicare Health Plan, so you won't need to send us a disenrollment request.

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

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

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

Termination of Contract with the Centers for Medicare & Medicaid Services

If our contract with the Centers for Medicare & Medicaid Services to offer Senior Advantage terminates, your Senior Advantage membership will terminate on the same date. We'll send you advance written notice and advise you of your health care options. Also, you may be eligible to transfer your membership to another Kaiser Permanente plan offered by your Group.

Termination for Cause

We may terminate your membership by sending you advance written notice if you commit one of the following acts:

- If you continuously behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for our other members. We cannot make you leave our Senior Advantage Plan for this reason unless we get permission from Medicare first
- If you let someone else use your plan membership card to get medical care. We cannot make you leave our Senior Advantage Plan for this reason unless we get permission from Medicare first. If you are disenrolled for this reason, the Centers for Medicare & Medicaid Services may refer your case to the Inspector General for additional investigation
- You commit theft from Health Plan, from a Plan Provider, or at a Plan Facility
- You intentionally misrepresent membership status or commit fraud in connection with your obtaining membership. We cannot make you leave our Senior Advantage Plan for this reason unless we get permission from Medicare first
- If you become incarcerated (go to prison)
- You knowingly falsify or withhold information about other parties that provide reimbursement for your prescription drug coverage

If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future until you have completed a Member Orientation and have signed a statement promising future compliance. We may report

fraud and other illegal acts to the authorities for prosecution.

Termination for Nonpayment of Premiums

If we do not receive Premiums for your Family, we may terminate the memberships of everyone in your Family.

Termination of a Product or all Products

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we'll terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's *Agreement* by sending you written notice at least 180 days before the *Agreement* terminates.

Payments after Termination

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

- Refund any amounts we owe for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Requests for Payment" section. We will deduct any amounts you owe Health Plan or Plan Providers from any payment we make to you

Review of Membership Termination

If you believe that we terminated your Senior Advantage membership because of your ill health or your need for care, you may file a complaint as described in the "Coverage Decisions, Appeals, and Complaints" section.

Continuation of Membership

If your membership under this Senior Advantage *EOC* ends, you may be eligible to continue Health Plan membership without a break in coverage. You may be able to continue Group coverage under this Senior Advantage *EOC* as described under "Continuation of Group Coverage." Also, you may be able to continue membership under an individual plan as described under "Conversion from Group Membership to an Individual Plan." If at any time you become entitled to continuation of Group coverage, please examine your coverage options carefully before declining this coverage. Individual plan premiums and coverage will be different from the premiums and coverage under your Group plan.

Continuation of Group Coverage

COBRA

You may be able to continue your coverage under this Senior Advantage *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal Consolidated Omnibus Budget Reconciliation Act ("COBRA"). COBRA applies to most employees (and most of their covered family Dependents) of most employers with 20 or more employees.

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll, you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Group for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and Premiums may change, and where to send your Premium payments.

As described in "Conversion from Group Membership to an Individual Plan" in this "Continuation of Membership" section, you may be able to convert to an individual (nongroup) plan if you don't apply for COBRA coverage, or if you enroll in COBRA and your COBRA coverage ends.

Coverage for a disabling condition

If you became Totally Disabled while you were a Member under your Group's *Agreement* with us and while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates and is not renewed, we will cover Services for your totally disabling condition until the earliest of the following events occurs:

- 12 months have elapsed since your Group's *Agreement* with us terminated
- You are no longer Totally Disabled
- Your Group's *Agreement* with us is replaced by another group health plan without limitation as to the disabling condition

Your coverage will be subject to the terms of this *EOC*, including Cost Share, but we will not cover Services for any condition other than your totally disabling condition.

For Subscribers and adult Dependents, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result

in death or has lasted or is expected to last for a continuous period of at least 12 months, and makes the person unable to engage in any employment or occupation, even with training, education, and experience.

For Dependent children, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the illness or injury makes the child unable to substantially engage in any of the normal activities of children in good health of like age.

To request continuation of coverage for your disabling condition, you must call Member Services within 30 days after your Group's *Agreement* with us terminates.

Conversion from Group Membership to an Individual Plan

After your Group notifies us to terminate your Group membership, we will send a termination letter to the Subscriber's address of record. The letter will include information about options that may be available to you to remain a Health Plan Member.

Kaiser Permanente Conversion Plan

If you want to remain a Health Plan Member, one option that may be available is our Senior Advantage Individual Plan. You may be eligible to enroll in our individual plan if you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section. Individual plan coverage begins when your Group coverage ends. The premiums and coverage under our individual plan are different from those under this *EOC* and will include Medicare Part D prescription drug coverage.

However, if you are no longer eligible for Senior Advantage and Group coverage, you may be eligible to convert to our non-Medicare individual plan, called "Kaiser Permanente Individual–Conversion Plan." You may be eligible to enroll in our Individual–Conversion Plan if we receive your enrollment application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

You may not be eligible to convert if your membership ends for the reasons stated under "Termination for Cause" or "Termination of *Agreement"* in the "Termination of Membership" section.

Miscellaneous Provisions

Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of your Group's *Agreement*, including this *EOC*.

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *EOC*, your Group is required to inform you in accord with applicable law and your Group's *Agreement*.

Applications and Statements

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

Assignment

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

Attorney and Advocate Fees and Expenses

In any dispute between a Member and Health Plan, the Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses.

Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this *EOC* and we have the discretionary authority to review and evaluate claims that arise under this *EOC*. We conduct this evaluation independently by interpreting the provisions of this *EOC*. We may use medical experts to help us review claims. If coverage under this *EOC* is subject to the Employee Retirement Income Security Act ("ERISA") claims procedure regulation (29 CFR 2560.503-1), then we are a "named claims fiduciary" to review claims under this *EOC*.

EOC Binding on Members

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

ERISA Notices

This "ERISA Notices" section applies only if your Group's health benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"). We provide these notices to assist ERISA-covered groups in complying with ERISA. Coverage for Services described in these notices is subject to all provisions of this *EOC*.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the birthing person or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the birthing person's or newborn's attending provider, after consulting with the birthing person, from discharging the birthing person or their newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same Cost Share applicable to other medical and surgical benefits provided under this plan.

Governing Law

Except as preempted by federal law, this *EOC* will be governed in accord with California law and any provision that is required to be in this *EOC* by state or federal law shall bind Members and Health Plan whether or not set forth in this *EOC*.

Group and Members Not Our Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

No Waiver

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

Notices Regarding Your Coverage

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call Member Services and Social Security toll free at **1-800-772-1213** (TTY users call **1-800-325-0778**) as soon as possible to give us their new address. If a Member does not reside with the Subscriber, or needs to have confidential information sent to an address other than the Subscriber's address, they should call Member Services to discuss alternate delivery options.

Note: When we tell your Group about changes to this *EOC* or provide your Group other information that affects you, your Group is required to notify the Subscriber within 30 days after receiving the information from us. The Subscriber is also responsible for notifying Group of any change in contact information.

Notice about Medicare Secondary Payer Subrogation Rights

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

Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment or from

any person or organization obligated to pay for the Services.

Public Policy Participation

The Kaiser Foundation Health Plan, Inc., Board of Directors establishes public policy for Health Plan. A list of the Board of Directors is available on our website at **kp.org** or from Member Services. If you would like to provide input about Health Plan public policy for consideration by the Board, please send written comments to:

Kaiser Foundation Health Plan, Inc.
Office of Board and Corporate Governance Services
One Kaiser Plaza, 19th Floor
Oakland, CA 94612

Telephone Access (TTY)

If you use a text telephone device (TTY, also known as TDD) to communicate by phone, you can use the California Relay Service by calling 711.

Phone Numbers and Resources

Kaiser Permanente Senior Advantage contacts

For help with claims, billing, or member card questions, call or write to our plan's Member Services. We'll be happy to help you.

Member Services – Contact Information

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

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

Member Services also has free language interpreter services available for non-English speakers.

TTY **711**

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

Write Your local Member Services office (see the Provider Directory for locations).

Website **kp.org**

How to ask for a coverage decision or appeal, or make a complaint about your medical care

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

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

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

Coverage Decisions, Appeals, or Complaints for Medical Care – Contact Information

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

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

If your coverage decision, appeal, or complaint qualifies for a fast decision as described in the "Coverage Decisions, Appeals, and Complaints" section, call the Expedited Review Unit at **1-888-987-7247**, 8:30 a.m. to 5 p.m., seven days a week.

TTY **711**

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

Fax If your coverage decision, appeal, or complaint qualifies for a fast decision, fax your request to our Expedited Review Unit at **1-888-987-2252**.

Write For a standard coverage decision or complaint, write to your local Member Services office (see the Provider Directory for locations).

For a standard appeal, write to the address shown on the denial notice we send you.

If your coverage decision, appeal, or complaint qualifies for a fast decision, write to:

Kaiser Permanente
Expedited Review Unit
P.O. Box 1809
Pleasanton, CA 94566

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

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

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

Coverage Decisions for Part D drugs – Contact Information

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

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

TTY **711**

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

Fax **1-844-403-1028**

Write OptumRx
c/o Prior Authorization
P.O. Box 2975
Mission, KS 66201

Website **kp.org**

How to ask for an appeal about your Part D drugs

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

Appeals for Part D drugs – Contact Information

Call **1-866-206-2973**

Calls to this number are free. Seven days a week, 8:30 a.m. to 5 p.m.

TTY **711**

Calls to this number are free. Seven days a week, 8:30 a.m. to 5 p.m.

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

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

Website **kp.org**

How to make a complaint about your Part D drugs

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

Complaints about Part D drugs – Contact Information

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

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

If your complaint qualifies for a fast decision, call the Part D Unit at **1-866-206-2973**, 8:30 a.m. to 5 p.m.,
seven days a week. Go to the "Coverage Decisions, Appeals, and Complaints" section to find out if your issue qualifies for a fast decision.

TTY **711**

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

Fax If your complaint qualifies for a fast review, fax your request to our Part D Unit at **1-866-206-2974**.

Write For a standard complaint, write to your local Member Services office (see the Provider Directory for locations).

If your complaint qualifies for a fast decision, write to:

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

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

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

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

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to the "Coverage Decisions, Appeals, and Complaints" section for more information.

Payment Requests – Contact Information

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

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

Note: If you're requesting payment of a Part D drug that was prescribed by a Plan Provider and obtained from a Plan Pharmacy, call our Part D unit at **1-866-206-2973**, 8:30 a.m. to 5 p.m., seven days a week.

TTY **711**

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

Write **For medical care:**

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

For Part D drugs:

If you're requesting payment of a Part D drug that was prescribed and provided by a Plan Provider, you can fax your request to **1-866-206-2974** or mail it to:

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

Website **kp.org**

Get help from Medicare

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

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

Medicare – Contact Information

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

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

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

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

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

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

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

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

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

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

State Health Insurance Assistance Program (SHIP)

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

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

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

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

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

TTY **711**

Write Your HICAP office for your county.

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

Quality Improvement Organization (QIO)

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

Contact Commence Health in any of these situations:

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

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

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

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

TTY **711**

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

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

Social Security

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

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

Social Security – Contact Information

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

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

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

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

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

Website **www.SSA.gov**

Medicaid

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

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other Cost Share. Some people with QMB are also eligible for full Medicaid benefits (QMB+)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. Some people

with SLMB are also eligible for full Medicaid benefits (SLMB+)

- **Qualifying Individual (QI):** Helps pay Part B premiums
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums

To find out more about Medicaid and Medicare Savings Programs, contact Medi-Cal.

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

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

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

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

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

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

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

Railroad Retirement Board (RRB)

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

Railroad Retirement Board (RRB) – Contact Information

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

Calls to this number are free.

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

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

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

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

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

Group Insurance or Other Health Insurance from an Employer

If you have any questions about your employer-sponsored Group plan, please contact your Group's benefits administrator. You can ask about your employer or retiree health benefits, any contributions toward the Group's premium, eligibility, and enrollment periods.

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

Important Notices

Notice of Language Assistance

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

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

Arabic: تنبيه. المساعدة اللغوية متوفرة بدون تكلفة عليك. يمكنك طلب خدمات الترجمة، بما في ذلك مترجمي لغة الإشارة. يمكنك طلب وثائق مترجمة بلغتك أو بصيغ بديلة مثل طريقة برايل للمكفوفين أو ملف صوتي أو الطباعة بأحرف كبيرة. يمكنك أيضًا طلب وسائل مساعدة وأجهزة مساعدة في مرافقنا. اتصل مع قسم خدمات الأعضاء لدينا للحصول على المساعدة. لا تعمل خدمات الأعضاء في العطلات الرئيسية.

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

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

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

Chinese：请注意，我们有免费语言协助。您可以要求我们提供口译服务，包括手语翻译员。您可以要求将资料翻译成您所使用的语言或其他格式的版本，如盲文、音频或大字版。您还可以要求使用我们设施中的语言辅助工具和设备。请联系会员服务部以获取帮助。重要节假日期间会员服务不开放。

- Medicare，包括 D-SNP：**1-800-443-0815** (TTY **711**)，每周 7 天，上午 8 点至晚上 8 点
- Medi-Cal：**1-855-839-7613** (TTY 711)，每周 7 天，每天 24 小时
- 所有其他保险计划：**1-800-757-7585** (TTY **711**)，每周 7 天，每天 24 小时

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

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

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

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

Hmong: FAJ SEEB. Muaj kev pab txhais lus pub dawb rau koj. Koj muaj peev xwm thov kom pab txhais lus, suav nrog kws txhais lus piav tes. Koj muaj peev xwm thov kom muab cov ntaub ntawv no txhais ua koj yam lus los sis ua lwm hom, xws li hom ntawv rau neeg dig muag xuas, tso ua suab lus, los sis luam tawm kom koj. Koj kuj tuaj yeem thov kom muab tej khoom pab dawb thiab tej khoom siv txhawb tau rau ntawm peb cov chaw kuaj mob. Hu mus thov kev pab

rau ntawm peb Lub Chaw Pab Tswv Cuab. Lub chaw pab tswv cuab kaw rau cov hnub so uas tseem ceeb.

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

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

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

Khmer (Cambodian): យកចិត្តទុកដាក់។ ជំនួយភាសាគឺមានដោយមិនគិតថ្លៃសម្រាប់អ្នក។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ រួមទាំងអ្នកបកប្រែភាសាសញ្ញាផងដែរ។ អ្នកអាចស្នើសុំឯកសារដែលត្រូវបានបកប្រែជាភាសារបស់អ្នក ឬទម្រង់ផ្សេងទៀតដូចជាអក្សរស្ដាប សំឡេង ឬអក្សរធំៗ។ អ្នកក៏អាចស្នើសុំជំនួយបន្ថែម និងឧបករណ៍ជំនួយនៅតាមកន្លែងរបស់យើងផងដែរ។ សូមទូរសព្ទទៅផ្នែកសេវាសមាជិករបស់យើងសម្រាប់ជំនួយ។ សេវាសមាជិកត្រូវបានបិទនៅថ្ងៃឈប់សម្រាកសំខាន់ៗ។

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

Korean: 안내 사항. 무료 언어 지원 제공. 수화 통역사를 포함한 통역 서비스를 요청할 수 있습니다. 한국어로 번역된 자료 또는 점자, 오디오 또는 큰 글씨와 같은 대체 형식의 자료를 요청할 수 있습니다. 저희 시설에서 보조 기구와 장치를 요청할 수도 있습니다. 가입자 서비스 부서에 도움을 요청하시기 바랍니다. 주요 공휴일에는 가입자 서비스를 운영하지 않습니다.

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

Laotian: ໂປດຊາບ. ມີການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ທ່ານສ າມາດຂໍບໍລິການນາຍພາສາ, ລວມທັງນາຍພາສາມື. ທ່ານ ສາມາດຂໍໃຫ້ແປເອກະສານນີ້ເປັນພາສາຂອງທ່ານ ຫຼື ຮູບ ແບບອື່ນ ເຊັ່ນ ອັກສອນນູນ, ສຽງ, ຫຼື ການພິມຂະໜາດໃ ຫຍ່. ນອກຈາກນັ້ນທ່ານຍັງສາມາດຮ້ອງຂໍເຄື່ອງຊ່ວຍຟັງ ແລະ ອຸປະກອນການຊ່ວຍເຫຼືອໃນສະຖານທີ່ຂອງພວກ ເຮົາ. ໂທຫາພະແນກບໍລິການສະມາຊິກຂອງພວກເຮົາເ ພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. ພະແນກບໍລິການສະມາຊິກແ ມ່ນປິດໃນວັນພັກທີ່ສໍາຄັນຕ່າງໆ.

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

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

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

Navajo: GIHA. Tséé' naalkáah sidá'ígíí éí doo tł'éé' íił'į' dah sidáa'ígíí. Tł'éé'góó tł'ízí'ígíí éí tséé' naalkáah sidá'ígíí bikáa' dah sidaaígíí, t'á'ii bik'eh dah na'ałkaígíí. T'á'ii éí tł'éé'góó tł'ízí'ígíí bik'eh dah deidiyós, t'á'ii éí bi'éé' bik'eh dah na'ałkaígíí bik'eh dah deidiyós. T'á'ii bik'eh dah na'ałkaígíí bikáa' dah na'ałkaígíí t'áá ałtso bik'eh dah deidiyós. Bi'éé' naalkáah sidá'ígíí bik'eh ha'a'aah. T'á'ii bik'eh dah na'ałkaígíí éí bik'eh dah naazhjaa'ígíí bik'eh dah na'ałkaígíí.

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

Punjabi: ਧਿਆਨ ਦਿਓ। ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ਿਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਿੱਤੇ ਜਾਣ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ, ਜਿਸ ਵਿੱਚ ਸਾਈਨ ਲੈਂਗੁਵੇਜ਼ ਦੇ ਦੁਭਾਸ਼ਿਏ ਵੀ ਸ਼ਾਮਲ ਹਨ। ਤੁਸੀਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ, ਜਾਂ ਕਿਸੇ ਵੈਕਲਪਿਕ ਫਾਰਮੈਟ ਵਿੱਚ ਅਨੁਵਾਦਿਤ ਕਰਨ ਲਈ ਵੀ ਕਹਿ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸਹੂਲਤਾਂ 'ਤੇ ਸਹਾਇਕ ਏਡਜ਼ ਅਤੇ ਉਪਕਰਨਾਂ ਲਈ ਵੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ ਸਾਡੇ ਮੈਂਬਰਾਂ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦੇ ਵਿਭਾਗ ਨੂੰ ਕਾੱਲ ਕਰੋ। ਮੈਂਬਰਾਂ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਾ ਵਿਭਾਗ ਮੁੱਖ ਛੁਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ।

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

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

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

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

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

Tagalog: PAUNAWA. May magagamit na tulong sa wika nang wala kang babayaran. Maaari kang humiling ng mga serbisyo ng interpreter, kasama ang mga interpreter sa sign language. Maaari kang humiling ng mga babasahin na nakasalin-wika sa iyong wika o sa mga alternatibong format, na tulad ng braille, audio, o malalaking titik. Puwede ka ring humiling ng mga karagdagang tulong at device sa aming mga pasilidad. Tawagan ang aming departamento ng Mga Serbisyo sa Miyembro para sa tulong. Ang mga serbisyo sa miyembro ay sarado sa mga pangunahing holiday.

- Medicare, kasama ang D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. hanggang 8 p.m., 7 araw sa isang linggo
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo
- Ang lahat ng iba: **1-800-464-4000** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo

Thai: ส่งถึง มีบริการให้ความช่วยเหลือด้านภาษา แก่ท่านโดยไม่มีค่าใช้จ่าย ท่านสามารถขอรับบริการล่าม รวมถึงล่ามภาษามือได้ ท่านสามารถขอให้แปลเอกสารเป็นภาษาของท่าน หรือในรูปแบบอื่นๆ เช่นอักษรเบรลล์ ไฟล์เสียง หรือตัวอักษรขนาดใหญ่ ท่านสามารถขอรับอุปกรณ์ ช่วยเหลือและอุปกรณ์เสริมได้ ณ สถานที่ให้บริการของเรา โทรติดต่อฝ่ายบริการสมาชิกของเราเพื่อขอความช่วยเหลือได้ ฝ่ายบริการสมาชิกจะปิดทำการในวันหยุดราชการต่างๆ

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

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

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

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

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

Nondiscrimination Notice

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

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

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

Kaiser Permanente provides the following services:

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

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

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

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

How to file a grievance with Kaiser Permanente

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

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

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

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

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

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

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

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

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

  California Department of Health Care Services Office of Civil Rights Complaint forms are available at: http://www.dhcs.ca.gov/Pages/Language_Access.aspx
- **Online:** Send an email to CivilRights@dhcs.ca.gov

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

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

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
  U.S. Department of Health and Human Services Office of Civil Rights Complaint forms are available at: https://www.hhs.gov/ocr/office/file/index.html
- **Online:** Visit the **Office of Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Southern California Region

A nonprofit corporation and a Medicare Advantage Organization

EOC #3 - Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage Evidence of Coverage for
AFFIRM INC

Group ID: 235801 Contract: 1 Version: 6 *EOC* Number: 3 Issue Date: October 21, 2025

January 1, 2026, through December 31, 2026

Member Services
Seven days a week, 8 a.m.–8 p.m.
1-800-443-0815 (TTY users call **711**)
kp.org

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

*Este documento está disponible de manera gratuita en español. Si desea información adicional, llame al número de nuestro Servicio a los Miembros al **1-800-443-0815**. (Los usuarios de TTY deben llamar al 711). El horario de atención es de 8 a. m. a 8 p. m., los 7 días de la semana.*

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

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

TABLE OF CONTENTS FOR EOC #3

Benefit Highlights 1
Introduction 3
About Kaiser Permanente 3
Term of this *EOC* 4
Definitions 4
Premiums, Eligibility, and Enrollment 10
Premiums 10
Medicare Premiums 10
Who Is Eligible 11
How to Enroll and When Coverage Begins 13
How to Obtain Services 15
Routine Care 15
Urgent Care 16
Our Advice Nurses 16
Your Personal Plan Physician 16
Getting a Referral 16
Travel and Lodging for Certain Services 17
Second Opinions 18
Contracts with Plan Providers 18
Receiving Care Outside of Your Home Region Service Area 19
Your ID Card 19
Getting Assistance 19
Plan Facilities 20
Provider Directory 20
Pharmacy Directory 20
Emergency Services and Urgent Care 20
Emergency Services 20
Urgent Care 21
Payment and Reimbursement 21
Benefits and Your Cost Share 22
Your Cost Share 23
Outpatient Care 25
Hospital Inpatient Services 26
Ambulance Services 27
Bariatric Surgery 28
Dental Services 28
Dialysis Care 29
Durable Medical Equipment (“DME”) for Home Use 29
Fertility Services 31
Fitness benefit (One Pass™) 32
Health Education 32
Hearing Services 33
Home Health Care 33
Hospice Care 34
Mental Health Services 34
Opioid Treatment Program Services 35
Ostomy, Urological, and Specialized Wound Care Supplies 35

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services 36
Outpatient Prescription Drugs, Supplies, and Supplements 37
Preventive Services 48
Prosthetic and Orthotic Devices 49
Reconstructive Surgery 50
Religious Nonmedical Health Care Institution Services 51
Services Associated with Clinical Trials 51
Skilled Nursing Facility Care 53
Substance Use Disorder Treatment 53
Telehealth Visits 54
Transplant Services 55
Vision Services 55
Exclusions, Limitations, Coordination of Benefits, and Reductions 56
Exclusions 56
Limitations 59
Coordination of Benefits 59
Reductions 60
Requests for Payment 61
Asking Us to Pay Our Share of a Bill for Covered Medical Services or Drugs 61
How to Ask Us to Pay You Back or Pay a Bill You Got 63
We'll Consider Your Request for Payment and Say *Yes* or *No* 63
Your Rights and Responsibilities 64
Our plan must honor your rights and cultural sensitivities 64
Your responsibilities as a Member of our plan 67
Coverage Decisions, Appeals, and Complaints 68
What to Do if You Have a Problem or Concern 68
Where To Get More Information and Personalized Help 68
Which Process to Use for Your Problem 69
A Guide to Coverage Decisions and Appeals 69
Medical Care: How to Ask for a Coverage Decision or Make an Appeal 71
Part D Drugs: How to Ask for a Coverage Decision or Make an Appeal 75
How to Ask Us to Cover a Longer Inpatient Hospital Stay if You Think You're Being Discharged Too Soon 80
How to Ask Us to Keep Covering Certain Medical Services if You Think Your Coverage Is Ending Too Soon 82
Taking Your Appeal to Levels 3, 4, and 5 84
How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns 85
You can also tell Medicare about your complaint 87
Additional Review 87
Binding Arbitration 87
Termination of Membership 89
Termination Due to Loss of Eligibility 89
Termination of *Agreement* 90
Disenrolling from Senior Advantage 90
Termination of Contract with the Centers for Medicare & Medicaid Services 91
Termination for Cause 91
Termination for Nonpayment of Premiums 91
Termination of a Product or all Products 91
Payments after Termination 91
Review of Membership Termination 91
Continuation of Membership 91
Continuation of Group Coverage 91
Conversion from Group Membership to an Individual Plan 92

Miscellaneous Provisions 92
Administration of Agreement 92
Amendment of *Agreement* 93
Applications and Statements 93
Assignment 93
Attorney and Advocate Fees and Expenses 93
Claims Review Authority 93
EOC Binding on Members 93
ERISA Notices 93
Governing Law 93
Group and Members Not Our Agents 93
No Waiver 93
Notices Regarding Your Coverage 94
Notice about Medicare Secondary Payer Subrogation Rights 94
Overpayment Recovery 94
Public Policy Participation 94
Telephone Access (TTY) 94
Phone Numbers and Resources 94
Kaiser Permanente Senior Advantage contacts 94
Get help from Medicare 96
State Health Insurance Assistance Program (SHIP) 97
Quality Improvement Organization (QIO) 97
Social Security 98
Medicaid 98
Railroad Retirement Board (RRB) 98
Group Insurance or Other Health Insurance from an Employer 99

Benefit Highlights

Plan Deductible	None
Plan Provider Office Visits	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	No charge
Most Physician Specialist Visits	No charge
Annual Wellness visit and the "Welcome to Medicare" preventive visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	No charge
Physical, occupational, and speech therapy	No charge
Telehealth Visits	**You Pay**
Primary Care Visits and Non-Physician Specialist Visits by interactive video	No charge
Physician Specialist Visits by interactive video	No charge
Primary Care Visits and Non-Physician Specialist Visits by telephone	No charge
Physician Specialist Visits by telephone	No charge
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	No charge
Allergy injections (including allergy serum)	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
Emergency Health Coverage	**You Pay**
Emergency Department visits	No charge

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share).

Ambulance and Transportation Services	**You Pay**
Ambulance Services	No charge
Prescription Drug Coverage	**You Pay**
This plan covers Medicare Part D prescription drugs in accord with our Part D formulary.	
Initial Coverage Stage—until you have spent $2,100 in 2026. (If you spend $2,100, you move on to the Catastrophic Coverage Stage)	No charge for up to a 100-day supply
Catastrophic Coverage Stage	No charge
Durable Medical Equipment (DME)	**You Pay**
Covered durable medical equipment for home use as described in this *EOC*	No charge
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	No charge
Group outpatient mental health treatment	No charge
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	No charge

Substance Use Disorder Treatment	You Pay
Group outpatient substance use disorder treatment	No charge

Home Health Services	You Pay
Home health care	No charge

Other	You Pay
Eyeglasses or contact lenses every 24 months	Amount in excess of $350 Allowance
Hearing aid(s) every 36 months	Amount in excess of $2,500 Allowance for each ear
Skilled Nursing Facility care	No charge
External prosthetic and orthotic devices as described in this *EOC*	No charge
Ostomy, urological, and specialized wound care supplies	No charge
Fitness benefit – One Pass™ (includes access to in-network gyms and one home fitness kit per calendar year)	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, refer to the "Benefits and Your Cost Share" and "Exclusions, Limitations, Coordination of Benefits, and Reductions" sections.

Introduction

Kaiser Foundation Health Plan, Inc. (Health Plan) has a contract with the Centers for Medicare & Medicaid Services as a Medicare Advantage Organization.

This contract provides Medicare Services (including Medicare Part D prescription drug coverage) through "Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage" (Senior Advantage), except for hospice care for Members with Medicare Part A, which is covered under Original Medicare. Enrollment in this Senior Advantage plan means that you are automatically enrolled in Medicare Part D. Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

This *Evidence of Coverage* ("*EOC*") describes our Senior Advantage health care coverage (when Medicare is secondary coverage under federal law) provided under the *Group Agreement (Agreement)* between Kaiser Foundation Health Plan, Inc. ("Health Plan") and your Group (the entity with which Health Plan has entered into the *Agreement*). The *Agreement* contains additional terms such as Premiums, when coverage can change, the effective date of coverage, and the effective date of termination. The *Agreement* must be consulted to determine the exact terms of coverage. A copy of the *Agreement* is available from your Group.

Members who have Medicare as their secondary coverage are entitled to the same group benefits under the same terms as Members who are not eligible for Medicare, as described in your Group's non-Medicare plan document. However, if you meet the eligibility requirements for this Kaiser Permanente Senior Advantage plan, you may also enroll in this Senior Advantage plan and receive benefits under the terms described in this *EOC*. You must continue to have primary coverage through your Group's non-Medicare plan in order to remain enrolled in this secondary Senior Advantage plan.

In this *EOC*, Health Plan is sometimes referred to as "we" or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *EOC*; please see the "Definitions" section for terms you should know.

It is important to familiarize yourself with your coverage by reading this *EOC* and your Group's non-Medicare plan document completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

As a Senior Advantage Member when Medicare is secondary, you must refer to both this *EOC* and your Group's non-Medicare plan document for the full description of your coverages, which are coordinated in accord with applicable law. Your non-Medicare plan document includes benefits not covered under this *EOC*, for example, state-mandated benefits and other terms that apply to non-Medicare plans. If you do not have your other (non-Medicare) plan document, please ask your Group for it.

About Kaiser Permanente

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY GET HEALTH CARE.

Kaiser Permanente provides Services directly to our Members through an integrated medical care program. Health Plan, Plan Hospitals, and the Medical Group work together to provide our Members with quality care. Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital Services, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *EOC*. Plus, our health education programs offer you great ways to protect and improve your health.

We provide covered Services to Members using Plan Providers located in our Service Area, which is described in the "Definitions" section. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Covered Services received outside of your Home Region Service Area as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
- COVID-19 Services as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits and Your Cost Share" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Your Cost Share" section

- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Your Cost Share" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section
- Routine Services associated with Medicare-approved clinical trials as described under "Services Associated with Clinical Trials" in the "Benefits and Your Cost Share" section

Term of this *EOC*

This *EOC* is for the period January 1, 2026, through December 31, 2026, unless amended. Benefits, Copayments, and Coinsurance may change on January 1 of each year and at other times in accord with your Group's *Agreement* with us. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has been amended.

Definitions

Some terms have special meaning in this *EOC*. When we use a term with special meaning in only one section of this *EOC*, we define it in that section. The terms in this "Definitions" section have special meaning when capitalized and used in any section of this *EOC*.

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

Note: Any Allowances in your Group's non-Medicare plan are coordinated with Allowances in this *EOC* and cannot be combined.

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

Centers for Medicare & Medicaid Services (CMS): The federal agency that administers the Medicare program.

Ancillary Coverage: Optional benefits such as acupuncture, chiropractic, or dental coverage that may be available to Members enrolled under this *EOC.* If your plan includes Ancillary Coverage, this coverage will be described in an amendment to this *EOC* or a separate agreement from the issuer of the coverage.

Charges: "Charges" means the following:

- For Services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members
- For Services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)
- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts your Cost Share from its payment, the amount Kaiser Permanente would have paid if it did not subtract your Cost Share

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service under this *EOC*.

Complaint: The formal name for making a complaint is **filing a grievance**. The complaint process is used only for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

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

Comprehensive Outpatient Rehabilitation Facility (CORF): A facility that mainly provides rehabilitation Services after an illness or injury, including physician's Services, physical therapy, social or psychological Services, and outpatient rehabilitation.

Copayment: A specific dollar amount that you must pay when you receive a covered Service under this *EOC*. Note: The dollar amount of the Copayment can be $0 (no charge).

Cost Share: The amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance. Cost Share also means any Charges you are required to pay for covered Medicare

Part D drugs. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible.

Coverage Determination: An initial determination we make about whether a Part D drug prescribed for you is covered under Part D and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription for a Part D drug to a Plan Pharmacy and the pharmacy tells you the prescription isn't covered by us, that isn't a Coverage Determination. You need to call or write us to ask for a formal decision about the coverage. Coverage Determinations are called "coverage decisions" in this *EOC*.

Dependent: A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

Durable Medical Equipment (DME): Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech-generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency Medical Condition: A medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

A mental health condition is an emergency medical condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to themselves or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

Emergency Services: Covered Services that are (1) rendered by a provider qualified to furnish Emergency Services; and (2) needed to treat, evaluate, or Stabilize an Emergency Medical Condition such as:

- A medical screening exam that is within the capability of the Emergency Department of a hospital, including ancillary services (such as imaging and laboratory Services) routinely available to the Emergency Department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post Stabilization Care and not Emergency Services)

***EOC*:** This *Evidence of Coverage* document, including any amendments, which describes the health care coverage of "Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage" under Health Plan's *Agreement* with your Group.

Extra Help: A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Family: A Subscriber and all of their Dependents.

Grievance: A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Group: The entity with which Health Plan has entered into the *Agreement* that includes this *EOC*.

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. This *EOC* sometimes refers to Health Plan as "we" or "us."

Home Region: The Region where you enrolled (either the Northern California Region or the Southern California Region).

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

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

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

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

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

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

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Organization: A public or private entity organized and licensed by a state as a risk-bearing entity that has a contract with the Centers for Medicare & Medicaid Services to provide Services covered by Medicare, except for hospice care covered by Original Medicare. Kaiser Foundation Health Plan, Inc., is a Medicare Advantage Organization.

Medicare Advantage Plan: Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be (i) an HMO, (ii) a PPO, (iii) a Private Fee-for-Service (PFFS) plan, or (iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. A person enrolled in a Medicare Part D plan has Medicare Part D by virtue of their enrollment in the Part D plan. This *EOC* is for a Medicare Part D plan.

Medicare Health Plan: A Medicare Health Plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage plans, Medicare Cost plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medigap (Medicare Supplement Insurance) Policy: Medicare supplement insurance sold by private insurance companies to fill *gaps* in the Original Medicare plan coverage. Medigap policies only work with the Original Medicare plan. (A Medicare Advantage Plan is not a Medigap policy.)

Member: A person who is eligible and enrolled under this *EOC*, and for whom we have received applicable Premiums. This *EOC* sometimes refers to a Member as "you."

Non-Physician Specialist Visits: Consultations, evaluations, and treatment by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

Non–Plan Hospital: A hospital other than a Plan Hospital.

Non–Plan Pharmacy: A pharmacy other than a Plan Pharmacy. These pharmacies are also called "out-of-network pharmacies."

Non–Plan Physician: A physician other than a Plan Physician.

Non–Plan Provider: A provider other than a Plan Provider.

Non–Plan Psychiatrist: A psychiatrist who is not a Plan Physician.

Non–Plan Skilled Nursing Facility: A Skilled Nursing Facility other than a Plan Skilled Nursing Facility.

Organization Determination: A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or Services. Organization determinations are called coverage decisions in this *EOC*.

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

parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your health resulting from an unforeseen illness or an unforeseen injury if all of the following are true:

- You are temporarily outside our Service Area
- A reasonable person would have believed that your health would seriously deteriorate if you delayed treatment until you returned to our Service Area

Physician Specialist Visits: Consultations, evaluations, and treatment by physician specialists, including personal Plan Physicians who are not Primary Care Physicians.

Plan Deductible: The amount you must pay under this *EOC* in the calendar year for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that calendar year. Refer to the "Benefits and Your Cost Share" section to learn whether your coverage includes a Plan Deductible, the Services that are subject to the Plan Deductible, and the Plan Deductible amount.

Plan Facility: Any facility listed in the Provider Directory on our website at **kp.org/facilities**. Plan Facilities include Plan Hospitals, Plan Medical Offices, and other facilities that we designate in the directory. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call Member Services.

Plan Hospital: Any hospital listed in the Provider Directory on our website at **kp.org/facilities**. In the directory, some Plan Hospitals are listed as Kaiser Permanente Medical Centers. The directory is updated periodically. The availability of Plan Hospitals may change. If you have questions, please call Member Services.

Plan Medical Office: Any medical office listed in the Provider Directory on our website at **kp.org/facilities**. In the directory, Kaiser Permanente Medical Centers may include Plan Medical Offices. The directory is updated periodically. The availability of Plan Medical Offices may change. If you have questions, please call Member Services.

Plan Optical Sales Office: An optical sales office owned and operated by Kaiser Permanente or another optical sales office that we designate. Refer to the Provider Directory on our website at **kp.org/facilities** for locations of Plan Optical Sales Offices. In the directory, Plan Optical Sales Offices may be called "Vision Essentials." The directory is updated periodically. The availability of Plan Optical Sales Offices may change. If you have questions, please call Member Services.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Refer to the Provider Directory on our website at **kp.org/facilities** for locations of Plan Pharmacies. The directory is updated periodically. The availability of Plan Pharmacies may change. If you have questions, please call Member Services.

Plan Physician: Any licensed physician who is a partner or employee of the Medical Group, or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that Health Plan designates as a Plan Provider.

Plan Skilled Nursing Facility: A Skilled Nursing Facility approved by Health Plan.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that this condition is clinically stable. You're considered clinically stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards that you're safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Premiums: The periodic amounts for your membership under this *EOC*.

Preventive Services: Covered Services that prevent or detect illness and do one or more of the following:

- Protect against disease and disability or further progression of a disease
- Detect disease in its earliest stages before noticeable symptoms develop

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Refer to the Provider Directory on our website at **kp.org** for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call Member Services.

Primary Care Visits: Evaluations and treatment provided by Primary Care Physicians and primary care Plan Providers who are not physicians (such as nurse practitioners).

Provider Directory: A directory of Plan Physicians and Plan Facilities in your Home Region. This directory is available on our website at **kp.org/directory**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call Member Services.

Real-Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 of each year and are currently the District of Columbia and parts of Northern California, Southern California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For the current list of Region locations, please visit our website at **kp.org** or call Member Services.

Serious Emotional Disturbance of a Child Under Age 18: A condition identified as a "mental disorder" in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:

- As a result of the mental disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
- The child displays psychotic features, or risk of suicide or violence due to a mental disorder
- The child meets special education eligibility requirements under Section 5600.3(a)(2)(C) of the Welfare and Institutions Code

Service Area: The geographic area approved by the Centers for Medicare & Medicaid Services within which an eligible person may enroll in Senior Advantage. Note: Subject to approval by the Centers for Medicare & Medicaid Services, we may reduce or expand our Service Area effective any January 1. ZIP codes are subject to change by the U.S. Postal Service. The ZIP codes below for each county are in our Service Area:

- Kern County: 93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93249-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-14, 93380, 93383-90, 93501-02, 93504-05, 93518-19, 93531, 93536, 93560-61, 93581
- Los Angeles County: 90001-84, 90086-89, 90091, 90093-96, 90099, 90134, 90140, 90189, 90201-02, 90205, 90209-13, 90220-24, 90230-32, 90239-42, 90245, 90247-51, 90254-55, 90260, 90262-67, 90270, 90272, 90274-75, 90277-78, 90280, 90290-96, 90301-12, 90401-11, 90501-10, 90601-10, 90623, 90630-31, 90637-40, 90650-52, 90660-62, 90670-71, 90701-03, 90706-07, 90710-17, 90723, 90731-34, 90744-49, 90755, 90801-10, 90813-15, 90822, 90831-33, 90840, 90842, 90844, 90846-48, 90853, 90895, 91001, 91003, 91006-12, 91016-17, 91020-21, 91023-25, 91030-31, 91040-43, 91046, 91066, 91077, 91101-10, 91114-18, 91121, 91123-26, 91129, 91182, 91184-85, 91188-89, 91199, 91201-10, 91214, 91221-22, 91224-26, 91301-11, 91313, 91316, 91321-22, 91324-28, 91330-31, 91333-35, 91337, 91340-46, 91350-57, 91361-62, 91364-65, 91367, 91371-72, 91376, 91380-87, 91390, 91392-96, 91401-13, 91416, 91423, 91426, 91436, 91470, 91482, 91499, 91501-08, 91510, 91521-23, 91601-10, 91614-18, 91702, 91706, 91711, 91714-16, 91722-24, 91731-35, 91740-41, 91744-50, 91754-56, 91759, 91765-73, 91775-76, 91778, 91780, 91788-93, 91801-04, 91896, 91899, 93243, 93510, 93532, 93534-36, 93539, 93543-44, 93550-53, 93560, 93563, 93584, 93586, 93590-91, 93599
- Orange County (whole county): 90620-24, 90630-33, 90638, 90680, 90720-21, 90740, 90742-43, 92602-07, 92609-10, 92612, 92614-20, 92623-30, 92637, 92646-63, 92672-79, 92683-85, 92688, 92690-94, 92697-98, 92701-08, 92711, 92728, 92735, 92780-82, 92799, 92801-09, 92811-12, 92814-17, 92821-23, 92825, 92831-38, 92840-46, 92856-57, 92859, 92861-71, 92885-87, 92899
- Riverside County: 91752, 92201-03, 92210-11, 92220, 92223, 92230, 92234-36, 92240-41, 92247-48, 92253, 92255, 92258, 92260-64, 92270, 92276, 92282, 92320, 92324, 92373, 92399, 92501-09, 92513-14, 92516-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72,

92581-87, 92589-93, 92595-96, 92599, 92860, 92877-83

- San Bernardino County: 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-59, 91761-64, 91766, 91784-86, 92305, 92307-08, 92313-18, 92321-22, 92324-25, 92329, 92331, 92333-37, 92339-41, 92344-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-95, 92397, 92399, 92401-08, 92410-11, 92413, 92415, 92418, 92423, 92427, 92880
- San Diego County: 91901-03, 91908-17, 91921, 91931-33, 91935, 91941-46, 91950-51, 91962-63, 91976-80, 91987, 92003, 92007-11, 92013-14, 92018-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-61, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92081-86, 92088, 92091-93, 92096, 92101-24, 92126-32, 92134-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-61, 92163, 92165-79, 92182, 92186-87, 92191-93, 92195-99
- Ventura County: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93001-07, 93009-12, 93015-16, 93020-22, 93030-36, 93040-44, 93060-66, 93094, 93099, 93252

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

Services: Health care services or items ("health care" includes both physical health care and mental health care) and services to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness.

Severe Mental Illness: The following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Spouse: The person to whom the Subscriber is legally married under applicable law. For the purposes of this *EOC*, the term "Spouse" includes the Subscriber's domestic partner. "Domestic partners" are two people who are registered and legally recognized as domestic partners by California (if your Group allows enrollment of domestic partners not legally recognized as domestic partners by California, "Spouse" also includes the Subscriber's domestic partner who meets your Group's eligibility requirements for domestic partners).

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant person who is having contractions, when there is inadequate time to safely transfer them to another hospital before delivery (or the transfer may pose a threat to the health or safety of the pregnant person or unborn child), "Stabilize" means to deliver (including the placenta).

Subscriber: A Member who is eligible for membership on their own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

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

Telehealth Visits: Interactive video visits and scheduled telephone visits between you and your provider.

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.

Premiums, Eligibility, and Enrollment

Premiums

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

Medicare Premiums

Medicare Part D Late Enrollment Penalty

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

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

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

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

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

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

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

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

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

Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this

amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit **https://www.Medicare.gov/health-drug-plans/part-d/basics/costs**.

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

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

Who Is Eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this "Who Is Eligible" section, including your Group's eligibility requirements and your Home Region Service Area eligibility requirements.

Group eligibility requirements

You must meet your Group's eligibility requirements such as the minimum number of hours that employees must work. Your Group is required to inform Subscribers of its eligibility requirements.

Senior Advantage eligibility requirements when Medicare is secondary

- You must have Medicare Part B
- You must be a United States citizen or lawfully present in the United States
- You must be simultaneously enrolled in your Group's non-Medicare plan as your primary coverage
- You must have Medicare as your secondary coverage in accord with federal law
- You may not be enrolled in another Medicare Health Plan or Medicare prescription drug plan

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

Service Area eligibility requirements

You must live in our Service Area, unless you have been continuously enrolled in Senior Advantage since December 31, 1998, and lived outside our Service Area during that entire time. In which case, you may continue your membership unless you move and are still outside your Home Region Service Area. The "Definitions" section describes our Service Area and how it may change.

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

Send your notice to:

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

It is in your best interest to notify us as soon as possible because until your Senior Advantage coverage is officially terminated by the Centers for Medicare & Medicaid Services, you will not be covered by us or Original Medicare for any care you receive from Non–Plan Providers, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Covered Services received outside of your Home Region Service Area as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Your Cost Share" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Your Cost Share" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs,

Supplies, and Supplements" in the "Benefits and Your Cost Share" section

- Routine Services associated with Medicare-approved clinical trials as described under "Services Associated with Clinical Trials" in the "Benefits and Your Cost Share" section

If you are not eligible to continue enrollment because you move to the service area of another Region, contact your Group to learn about your Group health care options. You may be able to enroll in the service area of another Region if there is an agreement between your Group and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*.

For more information about the service areas of the other Regions, please call Member Services.

Eligibility as a Subscriber

You may be eligible to enroll and continue enrollment as a Subscriber if you are:

- An employee of your Group
- A proprietor or partner of your Group
- Otherwise entitled to coverage under a trust agreement or employment contract (unless the Internal Revenue Service considers you self-employed)

Eligibility as a Dependent

Enrolling a Dependent

Dependent eligibility is subject to your Group's eligibility requirements, which are not described in this *EOC*. You can obtain your Group's eligibility requirements directly from your Group. If you are a Subscriber under this *EOC* and if your Group allows enrollment of Dependents, Health Plan allows the following persons to enroll as your Dependents under this *EOC*:

- Your Spouse
- Your or your Spouse's Dependent children, who meet the requirements described under "Age limit of Dependent children," if they are any of the following:
  - biological children
  - stepchildren
  - adopted children
  - children placed with you for adoption
  - foster children if you or your Spouse have the legal authority to direct their care
  - children for whom you or your Spouse is the court-appointed guardian (or was when the child reached age 18)
- Children whose parent is a Dependent child under your family coverage (including adopted children and children placed with your Dependent child for adoption or foster care) if they meet all of the following requirements:
  - they are not married and do not have a domestic partner (for the purposes of this requirement only, "domestic partner" means someone who is registered and legally recognized as a domestic partner by California)
  - they meet the requirements described under "Age limit of Dependent children"
  - they receive all of their support and maintenance from you or your Spouse
  - they permanently reside with you or your Spouse

Age limit of Dependent children

Children must be under age 26 as of the effective date of this *EOC* to enroll as a Dependent under your plan.

Dependent children are eligible to remain on the plan through the end of the month in which they reach the age limit.

Dependent children of the Subscriber or Spouse (including adopted children and children placed with you for adoption or foster care) who reach the age limit may continue coverage under this *EOC* if all of the following conditions are met:

- They meet all requirements to be a Dependent except for the age limit
- Your Group permits enrollment of Dependents
- They are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred before they reached the age limit for Dependents
- They receive 50 percent or more of their support and maintenance from you or your Spouse
- If requested, you give us proof of their incapacity and dependency within 60 days after receiving our request (see "Overage Dependent certification" below in this "Eligibility as a Dependent" section)

Overage Dependent certification

Proof may be required for a Dependent to be eligible to continue coverage as an overage Dependent. If we request it, the Subscriber must provide us documentation

of the dependent's incapacity and dependency as follows:

- If the child is a Member, we will send the Subscriber a notice of the Dependent's membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. The Dependent's membership will terminate as described in our notice unless the Subscriber provides us documentation of the Dependent's incapacity and dependency within 60 days of receipt of our notice and we determine that the Dependent is eligible as an overage dependent. If the Subscriber provides us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that the Dependent does not meet the eligibility requirements as an overage dependent, we will notify the Subscriber that the Dependent is not eligible and let the Subscriber know the membership termination date. If we determine that the Dependent is eligible as an overage dependent, there will be no lapse in coverage. Also, starting two years after the date that the Dependent reached the age limit, the Subscriber must provide us documentation of the Dependent's incapacity and dependency annually within 60 days after we request it so that we can determine if the Dependent continues to be eligible as an overage dependent
- If the child is not a Member because you are changing coverage, you must give us proof, within 60 days after we request it, of the child's incapacity and dependency as well as proof of the child's coverage under your prior coverage. In the future, you must provide proof of the child's continued incapacity and dependency within 60 days after you receive our request, but not more frequently than annually

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

How to Enroll and When Coverage Begins

Your Group is required to inform you when you're eligible to enroll and what your effective date of coverage is. If you're eligible to enroll as described under "Who Is Eligible" in this "Premiums, Eligibility, and Enrollment" section, enrollment is permitted as described below and membership begins at the beginning (12:00 a.m.) of the effective date of coverage indicated below, except that:

- Your Group may have additional requirements, which allow enrollment in other situations
- The effective date of your Senior Advantage coverage under this *EOC* must be confirmed by the Centers for Medicare & Medicaid Services, as described under "Effective date of Senior Advantage coverage" in this "How to Enroll and When Coverage Begins" section

If you're a Subscriber under this *EOC* and you have dependents who don't have Medicare Part B coverage or for some other reason aren't eligible to enroll under this *EOC*, you may be able to enroll them as your dependents under a non-Medicare plan offered by your Group. Contact your Group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

If you're eligible to be a Dependent under this *EOC* but the subscriber in your family is enrolled under a non-Medicare plan offered by your Group, the subscriber must follow the rules applicable to Subscribers who are enrolling Dependents in this "How to Enroll and When Coverage Begins" section.

Effective date of Senior Advantage coverage

After we receive your completed Senior Advantage Election Form, we'll submit your enrollment request to the Centers for Medicare & Medicaid Services for confirmation and send you a notice indicating the proposed effective date of your Senior Advantage coverage under this *EOC*.

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

New employees

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person, to your Group within 31 days.

Effective date of Senior Advantage coverage. The effective date of Senior Advantage coverage for new employees and their eligible family Dependents or newly acquired Dependents, is determined by your Group, subject to confirmation by the Centers for Medicare & Medicaid Services.

Group open enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person (or through an alternate, approved electronic process) to your Group during your Group's open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the effective date of coverage, which is subject to confirmation by the Centers for Medicare & Medicaid Services.

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

- You become eligible because you experience a qualifying event (sometimes called a "triggering event") as described in this "Special enrollment" section
- You did not enroll in any coverage offered by your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, from the Subscriber

Special enrollment due to new Dependents

You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, within 30 days after marriage, establishment of domestic partnership, birth, adoption, placement for adoption, or placement for foster care by submitting to your Group a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person.

Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application, and a Senior Advantage Election Form for each person, from the Subscriber. Subject to confirmation by the Centers for Medicare & Medicaid Services, enrollments of newly acquired Dependent children are effective as follows:

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

Special enrollment due to loss of other coverage. You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, if all of the following are true:

- The Subscriber or at least one of the Dependents had other coverage when they previously declined all coverage through your Group
- The loss of the other coverage is due to one of the following:
  - ♦ exhaustion of COBRA coverage
  - ♦ termination of employer contributions for non-COBRA coverage
  - ♦ loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, moving out of the plan's Service Area, reaching the age limit for dependent children, or the subscriber's death, termination of employment, or reduction in hours of employment
  - ♦ loss of eligibility (but not termination for cause) for coverage through Covered California, Medicaid coverage (known as Medi-Cal in California), Children's Health Insurance Program coverage, or Medi-Cal Access Program coverage
  - ♦ reaching a lifetime maximum on all benefits

Note: If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, only one of you must meet the requirements stated above.

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, to your Group within 30 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for

coverage through Covered California, Medicaid, Children's Health Insurance Program, or Medi-Cal Access Program coverage. Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application, and Senior Advantage Election Form for each person, from the Subscriber.

Special enrollment due to court or administrative order. Within 31 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person.

Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of coverage resulting from a court or administrative order is the first of the month following the date we receive the enrollment request, unless your Group specifies a different effective date (if your Group specifies a different effective date, the effective date cannot be earlier than the date of the order).

Special enrollment due to eligibility for premium assistance. You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, if you or a dependent become eligible for premium assistance through the Medi-Cal program. Premium assistance is when the Medi-Cal program pays all or part of premiums for employer group coverage for a Medi-Cal beneficiary. To request enrollment in your Group's health care coverage, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, to your Group within 60 days after you or a dependent become eligible for premium assistance. Please contact the California Department of Health Care Services to find out if premium assistance is available and the eligibility requirements.

Special enrollment due to reemployment after military service. If you terminated your health care coverage because you were called to active duty in the military service, you may be able to reenroll in your Group's health plan if required by state or federal law. Please ask your Group for more information.

How to Obtain Services

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Services" section
- Covered Services received outside of your Home Region Service Area as described under "Receiving Care Outside of Your Home Region Service Area" in this "How to Obtain Services" section
- COVID-19 Services as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits and Your Cost Share" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Your Cost Share" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Your Cost Share" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section
- Routine Services associated with Medicare-approved clinical trials as described under "Services Associated with Clinical Trials" in the "Benefits and Your Cost Share" section

Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital Services, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *EOC*.

Routine Care

To request a non-urgent appointment, you can call your local Plan Facility or request the appointment online. For appointment phone numbers, refer to our Provider Directory or call Member Services. To request an appointment online, go to our website at **kp.org**.

Urgent Care

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call Member Services.

For information about Out-of-Area Urgent Care, refer to "Urgent Care" in the "Emergency Services and Urgent Care" section.

Our Advice Nurses

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. Whether you are calling for advice or to make an appointment, you can speak to an advice nurse. They can often answer questions about a minor concern, tell you what to do if a Plan Medical Office is closed, or advise you about what to do next, including making a same-day Urgent Care appointment for you if it's medically appropriate. To reach an advice nurse, refer to our Provider Directory or call Member Services.

Your Personal Plan Physician

Personal Plan Physicians provide primary care and play an important role in coordinating care, including hospital stays and referrals to specialists.

We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal Plan Physicians. However, if you choose a specialist who is not designated as a Primary Care Physician as your personal Plan Physician, the Cost Share for a Physician Specialist Visit will apply to all visits with the specialist except for Preventive Services listed in the "Benefits and Your Cost Share" section.

To learn how to select or change to a different personal Plan Physician, visit our website at **kp.org**, or call Member Services. Refer to our Provider Directory for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call Member Services. You can change your personal Plan Physician at any time for any reason.

Getting a Referral

Referrals to Plan Providers

A Plan Physician must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, dermatology, and physical, occupational, and speech therapies. However, you do not need a referral or prior authorization to receive most care from any of the following Plan Providers:

- Your personal Plan Physician
- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, mental health Services, substance use disorder treatment, and obstetrics/gynecology

A Plan Physician must refer you before you can get care from a specialist in urology except that you do not need a referral to receive Services related to sexual or reproductive health, such as a vasectomy.

Although a referral or prior authorization is not required to receive most care from these providers, a referral may be required in the following situations:

- The provider may have to get prior authorization for certain Services in accord with "Medical Group authorization procedure for certain referrals" in this "Getting a Referral" section
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition

Standing referrals

If a Plan Physician refers you to a specialist, the referral will be for a specific treatment plan. Your treatment plan may include a standing referral if ongoing care from the specialist is prescribed. For example, if you have a life-threatening, degenerative, or disabling condition, you can get a standing referral to a specialist if ongoing care from the specialist is required.

Medical Group authorization procedure for certain referrals

The following are examples of Services that require prior authorization by the Medical Group for the Services to be covered ("prior authorization" means that the Medical Group must approve the Services in advance):

- Durable medical equipment
- Ostomy and urological supplies
- Services not available from Plan Providers
- Transplants

Utilization Management ("UM") is a process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UM process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at **kp.org/UM** or call Member Services to request a printed copy. Refer to "Post-Stabilization Care" under "Emergency Services" in the "Emergency Services and Urgent Care" section for authorization requirements that apply to Post-Stabilization Care from Non–Plan Providers.

Additional information about prior authorization for durable medical equipment, ostomy, urological, and specialized wound care supplies. The prior authorization process for durable medical equipment, ostomy, urological, and specialized wound care supplies includes the use of formulary guidelines. These guidelines were developed by a multidisciplinary clinical and operational work group with review and input from Plan Physicians and medical professionals with clinical expertise. The formulary guidelines are periodically updated to keep pace with changes in medical technology, Medicare guidelines, and clinical practice.

If your Plan Physician prescribes one of these items, they will submit a written referral in accord with the UM process described in this "Medical Group authorization procedure for certain referrals" section. If the formulary guidelines do not specify that the prescribed item is appropriate for your medical condition, the referral will be submitted to the Medical Group's designee Plan Physician, who will make an authorization decision as described under "Medical Group's decision time frames" in this "Medical Group authorization procedure for certain referrals" section.

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

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your physician will be informed of the scope of the authorized Services. If the Medical Group does not authorize all of the Services, Health Plan will send you a written decision and explanation within two business days after the decision is made. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request.

If the Medical Group does not authorize all of the Services requested and you want to appeal the decision, you can file a grievance as described in the "Coverage Decisions, Appeals, and Complaints" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Travel and Lodging for Certain Services

The following are examples of when we will arrange or provide reimbursement for certain travel and lodging expenses in accord with our Travel and Lodging Program Description:

- If Medical Group refers you to a provider that is more than 50 miles from where you live for certain specialty Services such as bariatric surgery, complex thoracic surgery, transplant nephrectomy, or inpatient chemotherapy for leukemia and lymphoma

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

For the complete list of specialty Services for which we will arrange or provide reimbursement for travel and lodging expenses, the amount of reimbursement, limitations and exclusions, and how to request reimbursement, refer to the Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at **kp.org/specialty-care/travel-reimbursements** or by calling Member Services.

Second Opinions

If you want a second opinion, you can ask Member Services to help you arrange one with a Plan Physician who is an appropriately qualified medical professional for your condition. If there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, Member Services will help you arrange a consultation with a Non–Plan Physician for a second opinion. For purposes of this "Second Opinions" provision, an "appropriately qualified medical professional" is a physician who is acting within their scope of practice and who possesses a clinical background, including training and expertise, related to the illness or condition associated with the request for a second medical opinion.

Here are some examples of when a second opinion may be provided or authorized:

- Your Plan Physician has recommended a procedure and you are unsure about whether the procedure is reasonable or necessary
- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions
- The clinical indications are not clear or are complex and confusing
- A diagnosis is in doubt due to conflicting test results
- The Plan Physician is unable to diagnose the condition
- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have concerns about the diagnosis or plan of care

An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial and of your right to file a grievance as described in the "Coverage Decisions, Appeals, and Complaints" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Contracts with Plan Providers

How Plan Providers are paid

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Physicians are paid to provide or arrange medical and hospital Services for Members, please visit our website at **kp.org** or call Member Services.

Financial liability

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may have to pay the full price of noncovered Services you obtain from Plan Providers or Non–Plan Providers.

When you are referred to a Plan Provider for covered Services, you pay the Cost Share required for Services from that provider as described in this *EOC*.

Termination of a Plan Provider's contract and completion of Services

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for the covered Services you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements.

Completion of Services. If you're undergoing treatment for specific conditions from a Plan Physician (or certain other providers) when the contract with them ends (for reasons other than medical disciplinary cause, criminal activity, or the provider's voluntary termination), you may be eligible to continue receiving covered care from the terminated provider for your condition. The

conditions that are subject to this continuation of care provision are:

- Certain conditions that are either acute, or serious and chronic. We may cover these Services for up to 90 days, or longer, if necessary for a safe transfer of care to a Plan Physician or other contracting provider as determined by the Medical Group
- A high-risk pregnancy or a pregnancy in its second or third trimester. We may cover these Services through postpartum care related to the delivery, or longer if Medically Necessary for a safe transfer of care to a Plan Physician as determined by the Medical Group

The Services must be otherwise covered under this *EOC*. Also, the terminated provider must agree in writing to our contractual terms and conditions and comply with them for Services to be covered by us.

For the Services of a terminated provider, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

More information. For more information about this provision, or to request the Services, call Member Services.

Receiving Care Outside of Your Home Region Service Area

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

Receiving care in another Kaiser Permanente service area

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

Receiving care outside of any Kaiser Permanente service area

If you are traveling outside of any Kaiser Permanente service area, we cover Services as described in the "Emergency Services and Urgent Care" section about Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care and the "Benefits and Your Cost Share" section about out-of-area dialysis care.

Your ID Card

Each Member's Kaiser Permanente ID card has a medical record number on it, which you will need when you call for advice, make an appointment, or go to a provider for covered care. When you get care, please bring your Kaiser Permanente ID card and a photo ID. Your medical record number is used to identify your medical records and membership information. Your medical record number should never change. Please call Member Services if we ever inadvertently issue you more than one medical record number or if you need to replace your Kaiser Permanente ID card.

Your ID card is for identification only. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-Member for any Services they receive. If you let someone else use your ID card, we may keep your ID card and terminate your membership as described under "Termination for Cause" in the "Termination of Membership" section.

Your Medicare card

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

Getting Assistance

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your personal Plan Physician or with other Plan Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Member Services

Member Services representatives can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain the following:

- Your Health Plan benefits
- How to make your first medical appointment

- What to do if you move
- How to replace your Kaiser Permanente ID card

Many Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, Member Services representatives are available to assist you seven days a week from 8 a.m. to 8 p.m. toll free at **1-800-443-0815** or **711** (TTY for the deaf, hard of hearing, or speech impaired). For your convenience, you can also contact us through our website at **kp.org**.

Cost Share estimates

For information about estimates, see "Getting an estimate of your Cost Share" under "Your Cost Share" in the "Benefits and Your Cost Share" section.

Plan Facilities

Plan Medical Offices and Plan Hospitals are listed in the Provider Directory for your Home Region. The directory describes the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services. This directory is available on our website at **kp.org/facilities**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call Member Services.

At most of our Plan Facilities, you can usually receive all of the covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you:

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available from Plan Hospital Emergency Departments (for Emergency Department locations, refer to our Provider Directory or call Member Services)
- Same-day Urgent Care appointments are available at many locations (for Urgent Care locations, refer to our Provider Directory or call Member Services)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services office (for locations, refer to our Provider Directory or call Member Services)
- Plan Pharmacies are located at most Plan Medical Offices (for pharmacy locations, refer to our Pharmacy Directory or call Member Services)

Provider Directory

The Provider Directory lists our Plan Providers. It is subject to change and periodically updated. If you don't have our Provider Directory, you can get a copy by calling Member Services or by visiting our website at **kp.org/directory**.

Pharmacy Directory

The Pharmacy Directory lists the locations of Plan Pharmacies, which are also called "network pharmacies." The pharmacy directory provides additional information about obtaining prescription drugs. It is subject to change and periodically updated. If you don't have the Pharmacy Directory, you can get a copy by calling Member Services or by visiting our website at **kp.org/directory**.

Emergency Services and Urgent Care

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest Emergency Department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non–Plan Providers anywhere in the world.

Emergency Services are available from Plan Hospital Emergency Departments 24 hours a day, seven days a week.

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that your condition is Stabilized.

To request prior authorization, the Non–Plan Provider must call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card *before* you receive the care. We will discuss your condition with the Non–Plan Provider. If we determine that you require Post-Stabilization Care and that this care is part of your

covered benefits, we will authorize your care from the Non–Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care with the treating physician's concurrence. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated Non–Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered.

Be sure to ask the Non–Plan Provider to tell you what care (including any transportation) we have authorized because we will not cover unauthorized Post-Stabilization Care or related transportation provided by Non–Plan Providers. If you receive care from a Non–Plan Provider that we have not authorized, you may have to pay the full cost of that care if you are notified by the Non–Plan Provider or us about your potential liability.

Your Cost Share

Your Cost Share for covered Emergency Services and Post-Stabilization Care is described in the "Benefits and Your Cost Share" section. Your Cost Share is the same whether you receive the Services from a Plan Provider or a Non–Plan Provider. For example:

- If you receive Emergency Services in the Emergency Department of a Non–Plan Hospital, you pay the Cost Share for an Emergency Department visit as described under "Outpatient Care"
- If we gave prior authorization for inpatient Post-Stabilization Care in a Non–Plan Hospital, you pay the Cost Share for hospital inpatient care as described under "Hospital Inpatient Care"

Urgent Care

Inside your Home Region Service Area

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For appointment and advice phone numbers, refer to our Provider Directory or call Member Services.

In the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC* (such as a major disaster, epidemic, war, riot, and civil insurrection), we cover Urgent Care inside our Service Area from a Non–Plan Provider.

Out-of-Area Urgent Care

If you need Urgent Care due to an unforeseen illness or unforeseen injury, we cover Medically Necessary Services to prevent serious deterioration of your health from a Non–Plan Provider if all of the following are true:

- You receive the Services from Non–Plan Providers while you are temporarily outside our Service Area
- A reasonable person would have believed that your health would seriously deteriorate if you delayed treatment until you returned to our Service Area

You do not need prior authorization for Out-of-Area Urgent Care. We cover Out-of-Area Urgent Care you receive from Non–Plan Providers if the Services would have been covered under this *EOC* if you had received them from Plan Providers.

We do not cover follow-up care from Non–Plan Providers after you no longer need Urgent Care. To obtain follow-up care from a Plan Provider, call the appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call Member Services.

Your Cost Share

Your Cost Share for covered Urgent Care is the Cost Share required for Services provided by Plan Providers as described in this *EOC*. For example:

- If you receive an Urgent Care evaluation as part of covered Out-of-Area Urgent Care from a Non–Plan Provider, you pay the Cost Share for Urgent Care consultations, evaluations, and treatment as described under "Outpatient Care"
- If the Out-of-Area Urgent Care you receive includes an X-ray, you pay the Cost Share for an X-ray as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services" in addition to the Cost Share for the Urgent Care evaluation

Note: If you receive Urgent Care in an Emergency Department, you pay the Cost Share for an Emergency Department visit as described under "Outpatient Care."

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Urgent Care from a Non–Plan Provider as described in this "Emergency Services and Urgent Care" section, or emergency ambulance Services described under "Ambulance Services" in the "Benefits and Your Cost Share" section, ask the Non–Plan Provider to submit a claim to us within 60 days or as soon as possible, but no later than 15 months after receiving the care (or up to 27 months according to Medicare rules, in some cases). If the provider refuses to bill us, send us the unpaid bill with a claim form. Also, if you receive

Services from a Plan Provider that are prescribed by a Non–Plan Provider as part of covered Emergency Services, Post-Stabilization Care, and Urgent Care (for example, drugs), you may be required to pay for the Services and file a claim. To request payment or reimbursement, you must file a claim as described in the "Requests for Payment" section.

We will reduce any payment we make to you or the Non–Plan Provider by the applicable Cost Share. Also, in accord with applicable law, we will reduce our payment by any amounts paid or payable (or that in the absence of this plan would have been payable) for the Services under any insurance policy, or any other contract or coverage, or any government program except Medicaid.

Benefits and Your Cost Share

This section describes the Services that are covered under this *EOC*.

Services are covered under this *EOC* as specifically described in this *EOC*. Services that are not specifically described in this *EOC* are not covered, except as required by federal law. Services are subject to exclusions and limitations described in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. Except as otherwise described in this *EOC*, all of the following conditions must be satisfied:

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
  - Preventive Services
  - health care items and services for diagnosis, assessment, or treatment
  - health education covered under "Health Education" in this "Benefits and Your Cost Share" section
  - other health care items and services
  - other services to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except for:
  - covered Services received outside of your Home Region Service Area, as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
  - COVID-19 Services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in this "Benefits and Your Cost Share" section
  - drugs prescribed by dentists, as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section
  - emergency ambulance Services, as described under "Ambulance Services" in this "Benefits and Your Cost Share" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
  - eyeglasses and contact lenses prescribed by Non–Plan Providers, as described under "Vision Services" in this "Benefits and Your Cost Share" section
  - out-of-area dialysis care, as described under "Dialysis Care" in this "Benefits and Your Cost Share" section
  - routine Services associated with Medicare-approved clinical trials, as described under "Services Associated with Clinical Trials" in this "Benefits and Your Cost Share" section
- You receive the Services from Plan Providers inside our Service Area, except for:
  - authorized referrals, as described under "Getting a Referral" in the "How to Obtain Services" section
  - covered Services received outside of your Home Region Service Area, as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
  - COVID-19 Services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in this "Benefits and Your Cost Share" section
  - emergency ambulance Services, as described under "Ambulance Services" in this "Benefits and Your Cost Share" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
  - out-of-area dialysis care, as described under "Dialysis Care" in this "Benefits and Your Cost Share" section

- ♦ prescription drugs from Non–Plan Pharmacies, as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section
- ♦ routine Services associated with Medicare-approved clinical trials, as described under "Services Associated with Clinical Trials" in this "Benefits and Your Cost Share" section

- The Medical Group has given prior authorization for the Services, if required, as described under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

Please also refer to:

- The "Emergency Services and Urgent Care" section for information about how to obtain covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care
- Our Provider Directory for the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services

Your Cost Share

Your Cost Share is the amount you are required to pay for covered Services. The Cost Share for covered Services is listed in this *EOC*. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible.

General rules, examples, and exceptions

Your Cost Share for covered Services will be the Cost Share in effect on the date you receive the Services, except as follows:

- If you are receiving covered hospital inpatient Services on the effective date of this *EOC*, you pay the Cost Share in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Share in effect on the date you receive the Services
- For items ordered in advance, you pay the Cost Share in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Share when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription

Payment toward your Cost Share (and when you may be billed)

In most cases, your provider will ask you to make a payment toward your Cost Share at the time you receive Services. If you receive more than one type of Services (such as primary care treatment and laboratory tests), you may be required to pay separate Cost Share for each of those Services. Keep in mind that your payment toward your Cost Share may cover only a portion of your total Cost Share for the Services you receive, and you will be billed for any additional amounts that are due. The following are examples of when you may be asked to pay (or you may be billed for) Cost Share amounts in addition to the amount you pay at check-in:

- You receive non-preventive Services during a preventive visit. For example, you go in for a routine physical exam, and at check-in you pay your Cost Share for the preventive exam (your Cost Share may be "no charge"). However, during your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional non-preventive diagnostic Services
- You receive diagnostic Services during a treatment visit. For example, you go in for treatment of an existing health condition, and at check-in you pay your Cost Share for a treatment visit. However, during the visit your provider finds a new problem with your health and performs or orders diagnostic Services (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional diagnostic Services
- You receive treatment Services during a diagnostic visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider confirms a problem with your health and performs treatment Services (such as an outpatient procedure). You may be asked to pay (or you will be billed for) your Cost Share for these additional treatment Services
- You receive Services from a second provider during your visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay (or you will be

billed for) your Cost Share for the consultation with the specialist

In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for your Cost Share (for example, some Laboratory Departments are not able to collect Cost Shares).

When we send you a bill, it will list Charges for the Services you received, payments and credits applied to your account, and any amounts you still owe. Your current bill may not always reflect your most recent Charges and payments. Any Charges and payments that are not on the current bill will appear on a future bill. Sometimes, you may see a payment but not the related Charges for Services. That could be because your payment was recorded before the Charges for the Services were processed. If so, the Charges will appear on a future bill. Also, you may receive more than one bill for a single outpatient visit or inpatient stay. For example, you may receive a bill for physician services and a separate bill for hospital services. If you don't see all the Charges for Services on one bill, they will appear on a future bill. If we determine that you overpaid and are due a refund, then we will send a refund to you within four weeks after we make that determination. If you have questions about a bill, please call the phone number on the bill.

In some cases, a Non–Plan Provider may be involved in the provision of covered Services at a Plan Facility or a contracted facility where we have authorized you to receive care. You are not responsible for any amounts beyond your Cost Share for the covered Services you receive at Plan Facilities or at contracted facilities where we have authorized you to receive care. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Requests for Payment" section.

Reimbursement for COVID-19 Services from Non-Plan Providers

If you receive covered COVID-19 Services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in this "Benefits and Your Cost Share" section, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Requests for Payment" section.

Primary Care Visits, Non-Physician Specialist Visits, and Physician Specialist Visits. The Cost Share for a Primary Care Visit applies to evaluations and treatment provided by generalists in internal medicine, pediatrics, or family practice, and by specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Some physician specialists provide primary care in addition to specialty care but are not designated as Primary Care Physicians. If you receive Services from one of these specialists, the Cost Share for a Physician Specialist Visit will apply to all consultations, evaluations, and treatment provided by the specialist except for routine preventive counseling and exams listed under "Preventive Services" in this "Benefits and Your Cost Share" section. For example, if your personal Plan Physician is a specialist in internal medicine or obstetrics/gynecology who is not a Primary Care Physician, you will pay the Cost Share for a Physician Specialist Visit for all consultations, evaluations, and treatment by the specialist except routine preventive counseling and exams listed under "Preventive Services" in this "Benefits and Your Cost Share" section. The Non-Physician Specialist Visit Cost Share applies to consultations, evaluations, and treatment provided by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

Provider fees

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

Noncovered services

If you receive services that are not covered under this *EOC*, you may have to pay the full price of those services. Payments you make for noncovered services do not apply to any deductible or out-of-pocket maximum.

Getting an estimate of your Cost Share

If you have questions about the Cost Share for specific Services that you expect to receive or that your provider orders during a visit or procedure, please visit our website at **kp.org** to use our cost estimate tool or call Member Services.

- If you have a Plan Deductible and would like an estimate for Services that are subject to the Plan Deductible, please call **1-800-390-3507** (TTY users call **711**) Monday through Friday, 6 a.m. to 5 p.m.
- For all other Cost Share estimates, please call Member Services

Cost Share estimates are based on your benefits and the Services you expect to receive. They are a prediction of cost and not a guarantee of the final cost of Services.

Your final cost may be higher or lower than the estimate since not everything about your care can be known in advance.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service, after you meet any applicable deductible, is described in this *EOC*.

Note: If Charges for Services are less than the Copayment or Coinsurance described in this *EOC*, you will pay the lesser amount.

Outpatient Care

We cover the following outpatient care subject to the Cost Share indicated:

Office visits

- Primary Care Visits and Non-Physician Specialist Visits that are not described elsewhere in this *EOC*: **no charge**
- Physician Specialist Visits that are not described elsewhere in this *EOC*: **no charge**
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician:
  - Primary Care Visits and Non-Physician Specialist Visits: **no charge**
  - Physician Specialist Visits: **no charge**
- Routine physical exams that are medically appropriate preventive care in accord with generally accepted professional standards of practice: **no charge**
- Family planning counseling, or internally implanted time-release contraceptives or intrauterine devices (IUDs) and office visits related to their administration and management: **no charge**
- After confirmation of pregnancy, the normal series of regularly scheduled preventive prenatal care exams and the first postpartum follow-up consultation and exam: **no charge**
- Voluntary termination of pregnancy and related Services: **no charge**
- Physical, occupational, and speech therapy in accord with Medicare guidelines: **no charge**
- Group and individual physical therapy prescribed by a Plan Provider to prevent falls: **no charge**
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program in accord with Medicare guidelines: **no charge**
- Manual manipulation of the spine to correct subluxation, in accord with Medicare guidelines, is covered by a participating chiropractor of the American Specialty Health Plans of California, Inc. (ASH Plans): **no charge**. (A referral by a Plan Physician is not required. For the list of participating ASH Plans providers, refer to the Provider Directory)

Acupuncture Services

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

Emergency Services and Urgent Care

- Urgent Care consultations, evaluations, and treatment: **no charge**
- Emergency Department visits: **no charge**

If you are admitted from the Emergency Department. If you are admitted to the hospital as an inpatient for covered Services (either within 24 hours for the same condition or after an observation stay), then the Services you received in the Emergency Department and observation stay, if applicable, will be considered part of your inpatient hospital stay. For the Cost Share for inpatient care, refer to "Hospital Inpatient Services" in this "Benefits and Your Cost Share" section. However, the Emergency Department Cost Share does apply if you are admitted for observation but are not admitted as an inpatient.

Outpatient surgeries and procedures

- Outpatient surgery and outpatient procedures when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member

monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **no charge**

- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **no charge**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this "Benefits and Your Cost Share" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Pre- and post-operative visits:
  - Primary Care Visits and Non-Physician Specialist Visits: **no charge**
  - Physician Specialist Visits: **no charge**

Administered drugs and products

Administered drugs and products are medications and products that require administration or observation by medical personnel. We cover these items when prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility or during home visits.

We cover the following Services and their administration in a Plan Facility at the Cost Share indicated:

- Whole blood, red blood cells, plasma, and platelets: **no charge**
- Allergy antigens (including administration): **no charge**
- Cancer chemotherapy drugs and adjuncts: **no charge**
- Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products ("biologics") derived from tissue, cells, or blood: **no charge**
- Tuberculosis skin tests: **no charge**
- All other administered drugs and products: **no charge**

We cover drugs and products administered to you during a home visit at **no charge**.

Certain administered drugs are Preventive Services. Refer to "Preventive Services" in this "Benefits and Your Cost Share" section for information on immunizations.

Note: Vaccines covered by Medicare Part D are not covered under this "Outpatient Care" section (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section).

For the following Services, refer to these sections

- Bariatric Surgery
- Dental Services
- Dialysis Care
- Durable Medical Equipment ("DME") for Home Use
- Fertility Services
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Mental Health Services
- Ostomy, Urological, and Specialized Wound Care Supplies
- Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services
- Outpatient Prescription Drugs, Supplies, and Supplements
- Preventive Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Substance Use Disorder Treatment
- Transplant Services
- Vision Services

Hospital Inpatient Services

We cover the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals inside our Service Area:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Plan Physicians, including consultation and treatment by specialists

- Anesthesia
- Drugs prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and other diagnostic and treatment Services, including MRI, CT, and PET scans
- Whole blood, red blood cells, plasma, platelets, and their administration
- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge (for visits after you are released from the hospital, please refer to "Outpatient Care" in this "Benefits and Your Cost Share" section)
- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program) in accord with Medicare guidelines
- Respiratory therapy
- Medical social services and discharge planning

Your Cost Share. We cover hospital inpatient Services at **no charge**.

For the following Services, refer to these sections

- Bariatric surgical procedures (refer to "Bariatric Surgery")
- Dental procedures (refer to "Dental Services")
- Dialysis care (refer to "Dialysis Care")
- Fertility Services related to diagnosis and treatment of infertility, artificial insemination, or assisted reproductive technology (refer to "Fertility Services")
- Hospice care (refer to "Hospice Care")
- Mental health Services (refer to "Mental Health Services")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Reconstructive surgery Services (refer to "Reconstructive Surgery")
- Religious Nonmedical Health Care Institution Services (refer to "Religious Nonmedical Health Care Institution")
- Services in connection with a clinical trial (refer to "Services in Connection with a Clinical Trial")
- Skilled inpatient Services in a Plan Skilled Nursing Facility (refer to "Skilled Nursing Facility Care")
- Substance use disorder treatment Services (refer to "Substance Use Disorder Treatment")
- Transplant Services (refer to "Transplant Services")

Ambulance Services

Emergency

We cover Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

- You reasonably believed that the medical condition was an Emergency Medical Condition which required ambulance Services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

If you receive emergency ambulance Services that are not ordered by a Plan Provider, you are not responsible for any amounts beyond your Cost Share for covered emergency ambulance Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Requests for Payment" section.

Nonemergency

Inside our Service Area, we cover nonemergency ambulance Services in accord with Medicare guidelines if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to and from qualifying locations as defined by Medicare guidelines.

Your Cost Share

You pay the following for covered ambulance Services:

- Emergency ambulance Services: **no charge**
- Nonemergency Services: **no charge**

Ambulance Services exclusions

- Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider

Bariatric Surgery

We cover hospital inpatient Services related to bariatric surgical procedures (including room and board, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

- You complete the Medical Group–approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success
- A Plan Physician who is a specialist in bariatric care determines that the surgery is Medically Necessary

Your Cost Share. For covered Services related to bariatric surgical procedures that you receive, you will pay the **Cost Share you would pay if the Services were not related to a bariatric surgical procedure**. For example, see "Hospital Inpatient Services" in this "Benefits and Your Cost Share" section for the Cost Share that applies for hospital inpatient Services.

For the following Services, refer to these sections

- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Dental Services

In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. Dental Services must be approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

Dental anesthesia

For dental procedures at a Plan Facility, we provide general anesthesia and the facility's Services associated with the anesthesia if all of the following are true:

- You are under age 7, or you are developmentally disabled, or your health is compromised
- Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
- The dental procedure would not ordinarily require general anesthesia

We do not cover any other Services related to the dental procedure, such as the dentist's Services, unless the Service is covered in accord with Medicare guidelines.

Your Cost Share

You pay the following for dental Services covered under this "Dental Services" section:

- Non-Physician Specialist Visits with dentists for Services covered under this "Dental Services" section: **no charge**
- Physician Specialist Visits for Services covered under this "Dental Services" section: **no charge**
- Outpatient surgery and outpatient procedures when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **no charge**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **no charge**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this "Benefits and Your Cost Share" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services): **no charge**

For the following Services, refer to these sections

- Office visits not described in this "Dental Services" section (refer to "Outpatient Care")
- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Dialysis Care

We cover acute and chronic dialysis Services if all of the following requirements are met:

- You satisfy all medical criteria developed by the Medical Group
- The facility is certified by Medicare
- A Plan Physician provides a written referral for your dialysis treatment except for out-of-area dialysis care

We also cover hemodialysis and peritoneal home dialysis (including equipment, training, and medical supplies). Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

Out-of-area dialysis care

We cover dialysis (kidney) Services that you get at a Medicare-certified dialysis facility when you are temporarily outside our Service Area. If possible, before you leave the Service Area, please let us know where you are going so we can help arrange for you to have maintenance dialysis while outside our Service Area.

The procedure for obtaining reimbursement for out-of-area dialysis care is described in the "Requests for Payment" section.

Your Cost Share. You pay the following for these covered Services related to dialysis:

- Equipment and supplies for home hemodialysis and home peritoneal dialysis: **no charge**
- One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment: **no charge**
- Hemodialysis and peritoneal dialysis treatment: **no charge**
- Hospital inpatient Services (including room and board, drugs, imaging, laboratory, and other diagnostic and treatment Services, and Plan Physician Services): **no charge**

For the following Services, refer to these sections

- Durable medical equipment for home use (refer to "Durable Medical Equipment ("DME") for Home Use")
- Hospital inpatient Services (refer to "Hospital Inpatient Services")
- Office visits not described in this "Dialysis Care" section (refer to "Outpatient Care")
- Kidney disease education (refer to "Health Education")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")
- Telehealth Visits (refer to "Telehealth Visits")

Dialysis care exclusions

- Comfort, convenience, or luxury equipment, supplies and features
- Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

Durable Medical Equipment ("DME") for Home Use

DME coverage rules

DME for home use is an item that meets the following criteria:

- The item is intended for repeated use
- The item is primarily and customarily used to serve a medical purpose
- The item is generally useful only to an individual with an illness or injury
- The item is appropriate for use in the home (or another location used as your home as defined by Medicare)
- The item is expected to last at least 3 years

For a DME item to be covered, all of the following requirements must be met:

- Your *EOC* includes coverage for the requested DME item
- A Plan Physician has prescribed the DME item for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor.

DME for diabetes

We cover the following diabetes testing supplies and equipment and insulin-administration devices if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met:

- Glucose monitors for diabetes testing and their supplies (such as glucose monitor test strips, lancets, and lancet devices)
- Insulin pumps and supplies to operate the pump

Your Cost Share. You pay the following for covered DME for diabetes (including repair or replacement of covered equipment):

- Glucose monitors for diabetes testing and their supplies (such as glucose monitor test strips, lancets, and lancet devices): **no charge**
- Insulin pumps and supplies to operate the pump: **no charge**

Base DME Items

We cover Base DME Items (including repair or replacement of covered equipment) if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met. "Base DME Items" means the following items:

- Glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Bone stimulator
- Canes (standard curved handle or quad) and replacement supplies
- Cervical traction (over door)
- Crutches (standard or forearm) and replacement supplies
- Dry pressure pad for a mattress
- Infusion pumps (such as insulin pumps) and supplies to operate the pump
- IV pole
- Nebulizer and supplies
- Phototherapy blankets for treatment of jaundice in newborns

Your Cost Share. You pay the following for covered Base DME Items: **no charge**.

Other covered DME items

If all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met, we cover the following other DME items (including repair or replacement of covered equipment):

- Bed accessories for a hospital bed when bed extension is required
- Heel or elbow protectors to prevent or minimize advanced pressure relief equipment use
- Iontophoresis device to treat hyperhidrosis when antiperspirants are contraindicated and the hyperhidrosis has created medical complications (for example, skin infection) or preventing daily living activities
- Nontherapeutic continuous glucose monitoring devices and related supplies
- Peak flow meters
- Resuscitation bag if tracheostomy patient has significant secretion management problems, needing lavage and suction technique aided by deep breathing via resuscitation bag

Your Cost Share. You pay the following for other covered DME items: **no charge**.

Outside our Service Area

We do not cover most DME for home use outside our Service Area. However, if you live outside our Service Area, we cover the following DME (subject to the Cost Share and all other coverage requirements that apply to DME for home use inside our Service Area) when the item is dispensed at a Plan Facility:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test

strips, lancets, and lancet devices) from a Plan Pharmacy
- Canes (standard curved handle)
- Crutches (standard)
- Nebulizers and their supplies for the treatment of pediatric asthma
- Peak flow meters from a Plan Pharmacy

For the following Services, refer to these sections

- Dialysis equipment and supplies required for home hemodialysis and home peritoneal dialysis (refer to "Dialysis Care")
- Diabetes urine testing supplies and insulin-administration devices other than insulin pumps (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Durable medical equipment related to the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Insulin and any other drugs administered with an infusion pump (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

DME for home use exclusions

- Comfort, convenience, or luxury equipment or features
- Dental appliances
- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including devices intended to provide additional support for recreational or sports activities)
- Hygiene equipment
- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car, unless covered in accord with Medicare guidelines
- Devices for testing blood or other body substances (except diabetes glucose monitors and their supplies)
- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to misuse

Fertility Services

"Fertility Services" means treatments and procedures to help you become pregnant.

Diagnosis and treatment of infertility

For purposes of this "Diagnosis and treatment of infertility" section, "infertility" means not being able to get pregnant or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception or having a medical or other demonstrated condition that is recognized by a Plan Physician as a cause of infertility. We cover the following:

- Services for the diagnosis and treatment of infertility
- Artificial insemination

You pay the following for covered infertility Services:

- Office visits: **no charge**
- Most outpatient surgery and outpatient procedures when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or provided in any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **no charge**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **no charge**
- Outpatient imaging: **no charge**
- Outpatient laboratory: **no charge**
- Outpatient administered drugs: **no charge**
- Hospital inpatient Services (including room and board, imaging, laboratory, and other diagnostic and treatment Services, and Plan Physician Services): **no charge**

Note: Administered drugs and products are medications and products that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility.

For the following Services, refer to these sections

- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Diagnostic Services provided by Plan Providers who are not physicians, such as EKGs and EEGs (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

Fertility Services exclusions

- Reversal of surgical sterilization originally performed for family planning purposes

- Semen and eggs (and Services related to their procurement and storage)
- Assisted reproductive technology Services, such as ovum transplants, gamete intrafallopian transfer (GIFT), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT)

Fitness benefit (One Pass™)

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

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

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

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

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

Fitness benefit exclusions

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

Health Education

We cover a variety of health education counseling, programs, and materials that your personal Plan Physician or other Plan Providers provide during a visit covered under another part of this *EOC*.

We also cover a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for tobacco cessation, stress management, and chronic conditions (such as diabetes and asthma). Kaiser Permanente also offers health education counseling, programs, and materials that are not covered, and you may be required to pay a fee.

For more information about our health education counseling, programs, and materials, contact your local Health Education Department, call Member Services or go to our website at **kp.org**.

Note: Our Health Education Department offers a comprehensive self-management workshop to help members learn the best choices in exercise, diet, monitoring, and medications to manage and control diabetes. Members may also choose to receive diabetes self-management training from a program outside our plan that is recognized by the American Diabetes Association (ADA) and approved by Medicare. Also, our Health Education Department offers education to teach kidney care and help members make informed decisions about their care.

Your Cost Share. You pay the following for these covered Services:

- Covered health education programs, which may include programs provided online and counseling over the phone: **no charge**
- Other covered individual counseling when the office visit is solely for health education: **no charge**
- Health education provided during an outpatient consultation or evaluation covered in another part of this *EOC*: **no additional Cost Share beyond the Cost Share required in that other part of this *EOC***
- Covered health education materials: **no charge**

Hearing Services

We cover the following:

- Hearing exams with an audiologist to determine the need for hearing correction: **no charge**
- Physician Specialist Visits to diagnose and treat hearing problems: **no charge**

Hearing aids

We cover the following Services related to hearing aids:

- A **$2,500 Allowance** for each ear toward the purchase price of a hearing aid (including fitting, counseling, adjustment, cleaning, and inspection during the 3-year warranty) every 36 months when prescribed by a Plan Physician or by a Plan Provider who is an audiologist. We'll cover hearing aids for both ears only if both aids are required to provide significant improvement that is not obtainable with only one hearing aid. We'll not provide the Allowance if we have provided an Allowance toward (or otherwise covered) a hearing aid within the previous 36 months. This also means that if your Group's non-Medicare plan includes coverage for hearing aids, the **$2,500 Allowance** reflects the coordination of the two coverages, thus they cannot be combined. Also, the Allowance can only be used at the initial point of sale. If you don't use all of your Allowance at the initial point of sale, you cannot use it later

We select the provider or vendor that will furnish the covered hearing aids. Coverage is limited to the types and models of hearing aids furnished by the provider or vendor.

For the following Services, refer to these sections

- Services related to the ear or hearing other than those described in this section, such as outpatient care to treat an ear infection or outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits and Your Cost Share" section)
- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Hearing Services exclusions

- Internally implanted hearing aids
- Replacement parts and batteries, repair of hearing aids, and replacement of lost or broken hearing aids (the manufacturer warranty may cover some of these)

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. We cover home health care only if all of the following are true:

- You are substantially confined to your home
- Your condition requires the Services of a nurse, physical therapist, or speech therapist or continued need for an occupational therapist (home health aide Services are not covered unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide)
- A Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home
- The Services are provided inside our Service Area

The Medical Group must authorize any home health nursing or other care of at least eight continuous hours, in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section (that authorization procedure does not apply to home health nursing or other care of less than eight continuous hours).

Your Cost Share. We cover home health care Services at **no charge**.

For the following Services, refer to these sections

- Dialysis care (refer to "Dialysis Care")
- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy, urological, and specialized wound care supplies (refer to "Ostomy, Urological, and Specialized Wound Care Supplies")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient physical, occupational, and speech therapy visits (refer to "Outpatient Care")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Home health care exclusions

- Care in the home if the home is not a safe and effective treatment setting

Hospice Care

We cover the hospice Services listed below at **no charge** only if all of the following requirements are met:

- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside our Service Area (or inside California but within 15 miles or 30 minutes from our Service Area if you live outside our Service Area, and you have been a Senior Advantage Member continuously since before January 1, 1999, at the same home address)
- The Services are provided by a licensed hospice agency that is a Plan Provider
- A Plan Physician determines that the Services are necessary for the palliation and management of your terminal illness and related conditions

If all of the above requirements are met, we cover the following hospice Services, if necessary for your hospice care:

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, and speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from a Plan Pharmacy. Certain drugs are limited to a maximum 30-day supply in any 30-day period (your Plan Pharmacy can tell you if a drug you take is one of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient Services limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling

We also cover the following hospice Services only during periods of crisis when they are Medically Necessary to achieve palliation or management of acute medical symptoms:

- Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
- Short-term inpatient Services required at a level that cannot be provided at home

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when the Services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, as amended in the most recently issued edition, *("DSM")* that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the *DSM* identifies as something other than a "mental disorder." For example, the *DSM* identifies relational problems as something other than a "mental disorder," so we do not cover services (such as couples counseling or family counseling) for relational problems.

"Mental Disorders" include the following conditions:

- Severe Mental Illness of a person of any age
- Serious Emotional Disturbance of a Child Under Age 18

In addition to the Services described in this Mental Health Services section, we also cover other Services that are Medically Necessary to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness, if the Medical Group authorizes a written referral (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Outpatient mental health Services

We cover the following Services when provided by Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license:

- Individual and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient Services for the purpose of monitoring drug therapy

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

- Partial hospitalization
- Multidisciplinary treatment in an intensive outpatient or day-treatment program
- Psychiatric observation for an acute psychiatric crisis

Your Cost Share. You pay the following for these covered Services:

- Individual mental health evaluation and treatment: **no charge**
- Group mental health treatment: **no charge**
- Partial hospitalization: **no charge**
- Other intensive psychiatric treatment programs: **no charge**

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized mental health treatment, the Services are generally and customarily provided by a mental health residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group mental health evaluation and treatment
- Medical services
- Medication monitoring
- Room and board
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section)
- Discharge planning

Your Cost Share. We cover residential mental health treatment Services at **no charge**.

Inpatient psychiatric hospitalization

We cover care for acute psychiatric conditions in a Medicare-certified psychiatric hospital.

Your Cost Share. We cover inpatient psychiatric hospital Services at **no charge**.

For the following Services, refer to these sections

- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory and sleep studies (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Telehealth Visits (refer to "Telehealth Visits")

Opioid Treatment Program Services

Members with opioid use disorder (OUD) can get coverage of Services to treat OUD through an Opioid Treatment Program (OTP) which includes the following Services:

- U.S. Food and Drug Administration (FDA) approved opioid agonist and antagonist medication-assisted treatment (MAT) medications and the dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments
- Medicare Part B clinically administered drugs

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

Ostomy, Urological, and Specialized Wound Care Supplies

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

- A Plan Physician has prescribed ostomy, urological, and specialized wound care supplies for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor.

Your Cost Share: You pay the following for covered ostomy, urological, and specialized wound care supplies: **no charge**.

Ostomy, urological, and specialized wound care supplies exclusions

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services

We cover the following Services at the Cost Share indicated only when part of care covered under other headings in this "Benefits and Your Cost Share" section. The Services must be prescribed by a Plan Provider:

- Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans: **no charge**
- Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds: **no charge**
- Nuclear medicine: **no charge**
- Routine preventive retinal photography screenings: **no charge**
- Routine laboratory tests to monitor the effectiveness of dialysis: **no charge**
- Hemoglobin (A1c) testing for diabetes, Low-Density Lipoprotein (LDL) testing for heart disease, International Normalized Ratio (INR) for persons with liver disease or certain blood disorders, and glucose quantitative blood tests not covered at $0 under Original Medicare: **no charge**
- Over-the-counter COVID-19 tests obtained from Plan Providers as described in this *EOC* (up to a total of 8 tests from Plan Providers and Non-Plan Providers per calendar month): **no charge**
- Over-the-counter COVID-19 tests obtained from Non-Plan Providers as described in this *EOC* (up to a total of 8 tests from Plan Providers and Non-Plan Providers per calendar month, not to exceed $12 per test, including all fees and taxes, if you obtain the test from a Non-Plan Provider): **50% Coinsurance**
- Laboratory tests to diagnose or screen for COVID-19 obtained from Plan Providers: **no charge**
- Laboratory tests to diagnose or screen for COVID-19 obtained from Non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care): **50% Coinsurance**
- All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available): **no charge**
- Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs, EEGs, and sleep studies): **no charge**
- Radiation therapy: **no charge**
- Ultraviolet light therapy treatments, including ultraviolet light therapy equipment for home use, if (1) the equipment has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section and (2) the equipment is provided inside your Home Region Service Area. (Coverage for ultraviolet light therapy equipment is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.): **no charge**

We cover laboratory tests to diagnose or screen for COVID-19 from Plan Providers or Non-Plan Providers, including a provider visit for purposes of receiving the laboratory test.

We cover up to a total of eight FDA-authorized over-the-counter COVID-19 tests per calendar month from Plan Providers or Non-Plan Providers. Over-the-counter tests are self-administered tests that deliver results at home and are available without a prescription. For purposes of this section, "Plan Provider" means a Plan Pharmacy, mail order delivery through our website at **kp.org**, or a participating retail pharmacy. For purposes of this section, a "Non-Plan Provider" means a pharmacy or online retailer that isn't a Plan Provider. To find out more about coverage and limitations, including the current list of Plan Providers, visit our website or call Member Services.

For the following Services, refer to these sections

- Outpatient imaging and laboratory Services that are Preventive Services, such as routine mammograms, bone density scans, and laboratory screening tests (refer to "Preventive Services")

- Outpatient procedures that include imaging and diagnostic Services (refer to "Outpatient surgeries and procedures")
- Services related to diagnosis and treatment of infertility, artificial insemination, or assisted reproductive technology ("ART") Services (refer to "Fertility Services")

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services exclusions

- Ultraviolet light therapy comfort, convenience, or luxury equipment or features
- Repair or replacement of ultraviolet light therapy equipment due to misuse

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, in accord with our drug formulary guidelines, subject to any applicable exclusions or limitations under this *EOC*. We cover items described in this section when prescribed as follows:

- Items prescribed by Plan Providers, within the scope of their licensure and practice
- Items prescribed by the following Non–Plan Providers unless a Plan Physician determines that the item is not Medically Necessary or the drug is for a sexual dysfunction disorder:
  - dentists if the drug is for dental care
  - Non–Plan Physicians if the Medical Group authorizes a written referral to the Non–Plan Physician (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section) and the drug, supply, or supplement is covered as part of that referral
  - Non–Plan Physicians if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described in the "Requests for Payment" section)
  - Non–Plan Providers that are not providers of Emergency Services or Out-of-Area Urgent Care if the prescription is for COVID-19 therapeutics (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described in the "Requests for Payment" section). Note: If you obtain a prescription from a Non-Plan Provider related to dental care or for COVID-19 therapeutics as described above, we do not cover an office visit or any other services from the Non-Plan Provider
- The item meets the requirements of our applicable drug formulary guidelines
- You obtain the item at a Plan Pharmacy or through our mail-order service unless you obtain the item from a Non-Plan Provider as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section or a Non-Plan Provider prescribes COVID-19 therapeutics for you, or as otherwise described under "Certain items from Non–Plan Pharmacies" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. Refer to our Pharmacy Directory for the locations of Plan Pharmacies in your area. Plan Pharmacies can change without notice and if a pharmacy is no longer a Plan Pharmacy, you must obtain covered items from another Plan Pharmacy, except as otherwise described under "Certain items from Non–Plan Pharmacies" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section
- Your prescriber must either accept Medicare or file documentation with the Centers for Medicare & Medicaid Services showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, be aware it takes time for your prescriber to submit the necessary paperwork to be processed

In addition to our plan's Part D and medical benefits coverage, if you have Medicare Part A, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please see "What if you're in a Medicare-certified hospice" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section.

Obtaining refills by mail

Most refills are available through our mail-order service, but there are some restrictions. A Plan Pharmacy, our Pharmacy Directory, or our website at **kp.org/refill** can give you more information about obtaining refills through our mail-order service. Check with your local Plan Pharmacy if you have a question about whether your prescription can be mailed. Items available through

our mail-order service are subject to change at any time without notice.

Certain items from Non–Plan Pharmacies

Generally, we cover drugs filled at a Non–Plan Pharmacy only when you aren't able to use a Plan Pharmacy. Check first with Member Services to see if there's a Plan Pharmacy nearby.

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

- The drug is related to covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section. Note: Prescription drugs prescribed and provided outside of the United States and its territories as part of covered Emergency Services or Urgent Care are covered up to a 30-day supply in a 30-day period. These drugs are not covered under Medicare Part D; therefore, payments for these drugs don't count toward reaching the Part D Catastrophic Coverage Stage
- For Medicare Part D covered drugs, the following are additional situations when a Part D drug may be covered:
  - if you are traveling within the United States and its territories but outside your Home Region Service Area and you become ill or run out of your covered Part D prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy in limited, nonroutine circumstances according to our Medicare Part D formulary guidelines
  - if you are unable to obtain a covered drug in a timely manner within your Home Region Service Area because there is no Plan Pharmacy within a reasonable driving distance that provides 24-hour service. We may not cover your prescription if a reasonable person could have purchased the drug at a Plan Pharmacy during normal business hours
  - if you are trying to fill a prescription for a drug that is not regularly stocked at an accessible Plan Pharmacy or available through our mail-order pharmacy (including high-cost drugs)
  - if you are not able to get your prescriptions from a Plan Pharmacy during a disaster

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

If you're in a Medicare-certified hospice

If you have Medicare Part A, drugs are never covered by both hospice and our plan at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, laxative, pain medication, or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

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

Medicare Part D drugs

Medicare Part D covers most outpatient prescription drugs if they are sold in the United States and approved for sale by the federal Food and Drug Administration. Our Part D formulary includes drugs that can be covered under Medicare Part D according to Medicare requirements and certain insulin administration devices (needles, syringes, alcohol swabs, and gauze). Refer to our "Medicare Part D drug formulary (2026 Comprehensive Formulary)" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section for more information about the Part D drug formulary.

Initial Coverage Stage

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

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

Cost Share for Medicare Part D drugs. Unless you reach the Catastrophic Coverage Stage in a calendar

year, you will pay the following Cost Share for covered Medicare Part D drugs in the Initial Coverage Stage:

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

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

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

Your Part D Explanation of Benefits (EOB) explains which payment stage you're in
Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

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

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

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

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

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
  - ♦ When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit
  - ♦ When you pay a copayment for drugs provided under a drug manufacturer patient assistance program
  - ♦ Any time you buy covered drugs at a Non–Plan Pharmacy or pay the full price for a covered drug under special circumstances
  - ♦ If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to the "Requests for Payments" section
- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs

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

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

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

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

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

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

Extra Help from Medicare

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

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

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

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

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

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

You or your appointed representative may need to provide the evidence to a Plan Pharmacy when obtaining covered Part D prescriptions so that we may charge you the appropriate Cost Share amount until the Centers for Medicare & Medicaid Services (CMS) updates its records to reflect your current status. Once CMS updates its records, you will no longer need to present the evidence to the Plan Pharmacy. Provide your evidence in one of the following ways so we can forward it to CMS for updating:

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

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

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

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

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

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

Medicare Prescription Payment Plan

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

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

If you disagree with the amount billed as part of this payment option, you can follow the steps described in the "Coverage Decisions. Appeals, and Complaints" section to make a complaint or appeal.

Medicare Part D drug formulary (2026 Comprehensive Formulary)

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

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

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

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

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

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

- Check the most recent Drug List we provided electronically at **kp.org/seniorrx**

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

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

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

The references in the formulary to preferred generic, generic, brand-name, non-preferred, and specialty tier drugs do not apply to you. All the drugs in the formulary are covered the same under your plan without regard for whether they are generic, brand, non-preferred, or specialty tier drugs. Note that sometimes a drug may appear more than once on our 2026 Comprehensive Formulary. This is because different restrictions or Cost Share may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

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

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

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

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

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

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

- ♦ we'll tell you at least 30 days before we make the change, or tell you about the change and cover a 30-day fill of the version of the drug you're taking

- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
  - ♦ sometimes a drug can be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you take that drug, we'll tell you after we make the change
- **Making other changes to drugs on the Drug List**
  - ♦ we may make other changes once the year has started that affect drugs you are taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare
  - ♦ we'll tell you at least 30 days before we make these changes, or tell you about the change and cover an additional 30-day fill of the drug you're taking

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

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

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

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

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

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

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

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

- Possible medication errors
- Drugs that may not be necessary because you take another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you take
- Unsafe amounts of opioid pain medications

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

Drug Management Program (DMP) to help members safely use opioid medications. We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You'll have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your request about the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to the "Coverage Decisions, Appeals, and Complaints" section for information about how to ask for an appeal.

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

Medication Therapy Management (MTM) program to help members manage medications. We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will get information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Keep your medication list up-to-date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Member Services.

Medicare Part D exclusions. Some kinds of prescription drugs are excluded. If you get drugs that are excluded (except for drugs described under "Outpatient drugs, supplies, and supplements not covered by Medicare"), you must pay for them yourself. If you appeal and the requested drug is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to the "Coverage Decisions, Appeals, and Complaints" section.) If a drug is not covered by Medicare Part D, any amounts you pay for that drug will not count toward reaching the Catastrophic Coverage Stage.

Here are 3 general rules about drugs that Medicare drug plans won't cover under Part D:

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B
- Our Plan can't cover a drug purchased outside the United States or its territories
- Our plan can't cover *off-label* use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the FDA

In addition, by law, the following categories of drugs aren't covered by Medicare drug plans:

- Nonprescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth

- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

If you get Extra Help to pay for your prescriptions, Extra Help program won't pay for drugs that aren't normally covered. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in the "Phone Numbers and Resources" section.)

Home infusion therapy

We cover home infusion supplies and drugs at **no charge** if all of the following are true:

- Your prescription drug is on our Medicare Part D formulary
- We approved your prescription drug for home infusion therapy
- Your prescription is written by a Plan Provider and filled at a Plan home-infusion pharmacy

Outpatient drugs covered by Medicare Part B

These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:

- Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services
- Insulin furnished through an item of durable medical equipment (such as a Medically Necessary insulin pump)
- Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan
- The Alzheimer's drug, Leqembi® (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment
- Clotting factors you give yourself by injection if you have hemophilia
- Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them
- Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug
- Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision
- Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does
- Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug
- Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases
- Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar®
- Certain drugs for home dialysis, including heparin, the antidote for heparin, when Medically Necessary, and topical anesthetics
- Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)
- Parenteral and enteral nutrition (intravenous and tube feeding)

We also cover some vaccines under Part B and most adult vaccines under our Part D drug benefit as described under "Medicare Part D drugs."

Your Cost Share for Medicare Part B drugs. You pay the following for Medicare Part B drugs:

- Generic drugs: **no charge for up to a 100-day supply**
- Brand-name and specialty drugs: **no charge for up to a 100-day supply**

Certain intravenous drugs, supplies, and supplements

We cover certain self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as an intravenous or intraspinal-infusion) at **no charge** for up to a 30-day supply. In addition, we cover the supplies and equipment required for the administration of these drugs at **no charge**.

Outpatient drugs, supplies, and supplements not covered by Medicare

We cover the following additional items not covered by Medicare Part B or D, in accord with our commercial drug formulary:

- Drugs for which a prescription is required by law. We also cover certain drugs that do not require a prescription by law if they are listed on our commercial drug formulary and prescribed by a Plan Physician
- Diaphragms, cervical caps, contraceptive rings, and contraceptive patches
- Disposable needles and syringes needed for injecting covered drugs and supplements
- Inhaler spacers needed to inhale covered drugs
- Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing
- FDA-approved medications for tobacco cessation, including over-the-counter medications when prescribed by a Plan Physician
- Therapeutics for COVID-19 obtained from Plan Providers and Non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care)

Your Cost Share for outpatient drugs, supplies, and supplements not covered by Medicare. Your Cost Share for these items is as follows:

- Items (that are not described elsewhere in this *EOC*): **no charge for up to a 100-day supply**
- Generic drugs prescribed for the treatment of sexual dysfunction disorders: **no charge for up to a 100-day supply**
- Brand drugs prescribed for the treatment of sexual dysfunction disorders: **no charge for up to a 100-day supply**
- Generic drugs prescribed for the treatment of infertility: **no charge for up to a 100-day supply**
- Brand drugs prescribed for the treatment of infertility: **no charge for up to a 100-day supply**
- Generic drugs related to covered assisted reproductive technology (ART) Services: **no charge for up to a 100-day supply**
- Brand drugs related to covered assisted reproductive technology (ART) Services: **no charge for up to a 100-day supply**
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria): **no charge for up to a 30-day supply**
- Elemental dietary enteral formula when used as a primary therapy for regional enteritis: **no charge for up to a 30-day supply**
- Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing: **no charge for up to a 100-day supply**
- Tobacco cessation drugs: **no charge**
- Therapeutics for COVID-19 obtained from Plan Providers: **no charge for up to a 30-day supply**
- Therapeutics for COVID-19 obtained from Non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care): **50% Coinsurance for up to a 30-day supply**

Note: If Charges for the drug, supply, or supplement are less than the Copayment or Coinsurance, you will pay the lesser amount.

Commercial drug formulary. The commercial drug formulary includes a list of drugs that our Pharmacy and Therapeutics Committee has approved for our Members. Our Pharmacy and Therapeutics Committee, which is primarily composed of Plan Physicians and pharmacists, selects drugs for the drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature. The drug formulary is updated monthly based on new information or new drugs that become available. To find out which drugs are on the formulary for your plan, refer to the California Commercial HMO formulary on our website at **kp.org/formulary**. The formulary also discloses

requirements or limitations that apply to specific drugs, such as whether there is a limit on the amount of the drug that can be dispensed and whether the drug must be obtained at certain specialty pharmacies. If you would like to request a copy of this drug formulary, call Member Services. Note: The presence of a drug on the drug formulary does not necessarily mean that it will be prescribed for a particular medical condition.

Our Commercial drug formulary guidelines allow you to obtain a non-formulary prescription drug (those not listed on our drug formulary for your condition) if it would otherwise be covered by your plan, as described above, and it is Medically Necessary. If you disagree with a Health Plan determination that a non-formulary prescription drug is not covered, you may file a grievance as described in the "Coverage Decisions, Appeals, and Complaints" section.

Continuity drugs. If this *EOC* is amended to exclude a drug that we have been covering and providing to you under this *EOC*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration.

About specialty drugs. Specialty drugs are high-cost drugs that are on our specialty drug list. If your Plan Physician prescribes more than a 30-day supply for an outpatient drug, you may be able to obtain more than a 30-day supply at one time, up to the day supply limit for that drug. However, most specialty drugs are limited to a 30-day supply in any 30-day period. Your Plan Pharmacy can tell you if a drug you take is one of these drugs.

Manufacturer coupon program. For outpatient prescription drugs or items that are covered under the "Outpatient drugs, supplies, and supplements not covered by Medicare" section and obtained at a Plan Pharmacy, you may be able to use approved manufacturer coupons as payment for the Cost Share that you owe, as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire amount of your Cost Share for your prescription. Certain health plan coverages are not eligible for coupons. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at **kp.org/rxcoupons**.

For the following Services, refer to these sections

- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "Durable Medical Equipment for Home Use")
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care")
- Drugs prescribed for pain control and symptom management of the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Durable medical equipment used to administer drugs (refer to "Durable Medical Equipment for Home Use")
- Outpatient administered drugs (refer to "Outpatient Care")
- Vaccines covered by Medicare Part B (refer to "Preventive Services")

Outpatient prescription drugs, supplies, and supplements not covered by Medicare limitations

- The prescribing physician or dentist determines how much of a drug, supply, item, or supplement to prescribe. For purposes of day supply coverage limits, Plan Physicians determine the amount of an item that constitutes a Medically Necessary 30- or 100-day supply for you. Upon payment of the Cost Share specified in the "Outpatient prescription drugs, supplies, and supplements," you will receive the supply prescribed up to the day supply limit specified in this section or in the drug formulary for your plan (see "Commercial drug formulary" above). The maximum you may receive at one time of a covered item, is either one 30-day supply in a 30-day period or one 100-day supply in a 100-day period. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantities that exceed the day supply limit
- For sexual dysfunction drugs, the maximum you may receive at one time of episodic drugs prescribed for the treatment of sexual dysfunction disorders is eight doses in any 30-day period or up to 27 doses in any 100-day period
- The pharmacy may reduce the day supply dispensed at the Cost Share specified under "Outpatient prescription drugs, supplies, and supplements not covered by Medicare" for any drug to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for

specific drugs (your Plan Pharmacy can tell you if a drug you take is one of these drugs)

Outpatient prescription drugs, supplies, and supplements not covered by Medicare exclusions

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging
- Compounded products unless the drug is listed on one of our drug formularies or one of the ingredients requires a prescription by law
- Drugs prescribed to shorten the duration of the common cold
- Prescription drugs for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the prescription drug). This exclusion does not apply to:
  - ♦ insulin
  - ♦ over-the-counter tobacco cessation drugs and contraceptive drugs
  - ♦ an entire class of prescription drugs when one drug within that class becomes available over-the-counter
- Drugs when prescribed solely for the purposes of losing weight, except when Medically Necessary for the treatment of morbid obesity. We may require Members who are prescribed drugs for morbid obesity to be enrolled in a covered comprehensive weight loss program, for a reasonable period of time prior to or concurrent with receiving the prescription drug

Preventive Services

We cover a variety of Preventive Services in accord with Medicare guidelines. The list of Preventive Services is subject to change by the Centers for Medicare & Medicaid Services. These Preventive Services are subject to all coverage requirements described in this "Benefits and Your Cost Share" section and all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. If you have questions about Preventive Services, please call Member Services.

Note: If you receive any other covered Services that are not Preventive Services during or subsequent to a visit that includes Preventive Services on the list, you will pay the applicable Cost Share for those other Services. For example, if laboratory tests or imaging Services ordered during a preventive office visit are not Preventive Services, you will pay the applicable Cost Share for those Services.

Your Cost Share. You pay the following for covered Preventive Services:

- Abdominal aortic aneurysm screening: **no charge**
- Annual Wellness visit: **no charge**
- Bone mass measurement: **no charge**
- Breast cancer screening (mammograms): **no charge**
- Cardiovascular disease risk reduction visit (therapy for cardiovascular disease): **no charge**
- Cardiovascular disease screening tests: **no charge**
- Cervical and vaginal cancer screening: **no charge**
- Colorectal cancer screening, including flexible sigmoidoscopies, colonoscopies, and fecal occult blood tests: **no charge**
- Depression screening: **no charge**
- Diabetes screening, including fasting glucose tests: **no charge**
- Diabetes self-management training: **no charge**
- Glaucoma screening: **no charge**
- HIV screening: **no charge**
- Immunizations (including the vaccine) covered by Medicare Part B such as Hepatitis B, flu/influenza, pneumococcal, and COVID-19 vaccines that are administered to you in a Plan Medical Office: **no charge**
- Immunizations (including the vaccine) for COVID-19 administered by Non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care): **50% Coinsurance** (we do not cover an office visit or any other services from the Non-Plan Provider other than administration of the vaccine)
- Lung cancer screening with low dose computed tomography (LDCT): **no charge**
- Medical nutrition therapy for kidney disease and diabetes: **no charge**
- Medicare diabetes prevention program (MDPP): **no charge**
- Obesity screening and therapy to promote sustained weight loss: **no charge**
- Pre-exposure prophylaxis (PrEP) for HIV prevention: **no charge**
- Prostate cancer screening exams, including digital rectal exams and Prostate Specific Antigen (PSA) tests: **no charge**
- Screening for Hepatitis C Virus infection: **no charge**

- Screening and counseling to reduce alcohol misuse: **no charge**
- Screening for sexually transmitted infections (STIs) and counseling to prevent STIs: **no charge**
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use): **no charge**
- Welcome to Medicare preventive visit: **no charge**

Prosthetic and Orthotic Devices

Prosthetic and orthotic devices coverage rules

We cover the prosthetic and orthotic devices specified in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage includes fitting and adjustment of these devices, their repair or replacement, and Services to determine whether you need a prosthetic or orthotic device. If we cover a replacement device, then you pay the Cost Share that you would pay for obtaining that device.

Base prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the items described in this "Base prosthetic and orthotic devices" section.

Internally implanted devices. We cover prosthetic and orthotic devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, in accord with Medicare guidelines, if they are implanted during a surgery that we are covering under another section of this "Benefits and Your Cost Share" section. We cover these devices at **no charge**.

External devices. We cover the following external prosthetic and orthotic devices at **no charge**:

- Prosthetics and orthotics in accord with Medicare guidelines. These include, but are not limited to, braces, prosthetic shoes, artificial limbs, and therapeutic footwear for severe diabetes-related foot disease in accord with Medicare guidelines
- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- After Medically Necessary removal of all or part of a breast, prosthesis including custom-made prostheses when Medically Necessary
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Enteral pump and supplies
- Tracheostomy tube and supplies
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

Other covered prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the following items described in this "Other covered prosthetic and orthotic devices" section:

- Prosthetic devices required to replace all or part of an organ or extremity, in accord with Medicare guidelines
- Vacuum erection device for sexual dysfunction
- Certain surgical boots following surgery when provided during an outpatient visit
- Orthotic devices required to support or correct a defective body part, in accord with Medicare guidelines
- Covered special footwear when custom made for foot disfigurement due to disease, injury, or developmental disability

Your Cost Share. You pay the following for other covered prosthetic and orthotic devices: **no charge**. For

internally implanted prosthetic and orthotic devices, you pay the Cost Share for the procedure to implant the device. For example, see "Outpatient Care" in this "Benefits and Your Cost Share" section for the Cost Share that applies for outpatient surgery.

For the following Services, refer to these sections

- Eyeglasses and contact lenses, including contact lenses to treat aniridia or aphakia (refer to "Vision Services")
- Eyewear following cataract surgery (refer to "Vision Services")
- Hearing aids other than internally implanted devices described in this section (refer to "Hearing Services")
- Injectable implants (refer to "Administered drugs and products" under "Outpatient Care")

Prosthetic and orthotic devices exclusions

- Dental appliances
- Nonrigid supplies not covered by Medicare, such as elastic stockings and wigs, except as otherwise described above in this "Prosthetic and Orthotic Devices" section and the "Ostomy, Urological, and Specialized Wound Care Supplies" section
- Comfort, convenience, or luxury equipment or features
- Repair or replacement of device due to misuse
- Shoes, shoe inserts, arch supports, or any other footwear, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications and foot disfigurement
- Prosthetic and orthotic devices not intended for maintaining normal activities of daily living (including devices intended to provide additional support for recreational or sports activities)
- Nonconventional intraocular lenses (IOLs) following cataract surgery (for example, presbyopia-correcting IOLs). You may request and we may provide insertion of presbyopia-correcting IOLs or astigmatism-correcting IOLs following cataract surgery in lieu of conventional IOLs. However, you must pay the difference between Charges for nonconventional IOLs and associated services and Charges for insertion of conventional IOLs following cataract surgery

Reconstructive Surgery

We cover the following reconstructive surgery Services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Plan Physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible
- Following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

Your Cost Share. You pay the following for covered reconstructive surgery Services:

- Outpatient surgery and outpatient procedures when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **no charge**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **no charge**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this "Benefits and Your Cost Share" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services): **no charge**

For the following Services, refer to these sections

- Office visits not described in this "Reconstructive Surgery" section (refer to "Outpatient Care")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

- Outpatient administered drugs (refer to "Outpatient Care")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Telehealth Visits (refer to "Telehealth Visits")

Reconstructive surgery exclusions

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance

Religious Nonmedical Health Care Institution Services

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

To get care from a religious non-medical health care institution, you must sign a legal document that says you're conscientiously opposed to getting medical treatment that is non-excepted.

- **Non-excepted** medical care or treatment is any medical care or treatment that's voluntary and not required by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that's not voluntary or is required under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan only covers *non-religious* aspects of care.

If you get services from this institution provided to you in a facility, the following conditions apply:

- You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care
- *– and –* you must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered

Note: Covered Services are subject to the same limitations and Cost Share required for Services provided by Plan Providers as described in this "Benefits and Your Cost Share" section.

Services Associated with Clinical Trials

We cover Services you receive in connection with a clinical trial if all of the following requirements are met:

- We would have covered the Services if they were not related to a clinical trial
- You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
  - a Plan Provider makes this determination
  - you provide us with medical and scientific information establishing this determination
- If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live
- The clinical trial is an Approved Clinical Trial

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition, and that meets one of the following requirements:

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having an investigational new drug application
- The study or investigation is approved or funded by at least one of the following:
  - the National Institutes of Health
  - the Centers for Disease Control and Prevention
  - the Agency for Health Care Research and Quality
  - the Centers for Medicare & Medicaid Services
  - a cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs
  - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants

- the Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review

Your Cost Share. For covered Services related to a clinical trial, you will pay the **Cost Share you would pay if the Services were not related to a clinical trial**. For example, see "Hospital Inpatient Services" in this "Benefits and Your Cost Share" section for the Cost Share that applies for hospital inpatient Services.

Services covered by Medicare

If you do not meet the requirements above, you may be able to participate in a Medicare-approved clinical research study, Original Medicare (and not Senior Advantage) pays most of the routine costs for the covered Services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in Senior Advantage and continue to get the rest of your care (the care that is not related to the study) through our plan.

A clinical research study (also called a clinical trial) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in Senior Advantage and continue to get the rest of your care (care that's not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered Services you receive as part of the study. If you tell us you're in a qualified clinical trial, you're only responsible for the in-network cost sharing for the services in that trial. If you paid more—for example, if you already paid the Original Medicare cost-sharing amount—we'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study
- An operation or other medical procedure if it's part of the research study
- Treatment of side effects and complications of the new care

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to the "Requests for Payment" section for more information on submitting requests for payments.

Get more information about joining a clinical research study in the Medicare publication Medicare and Clinical Research Studies, available at **https://www.medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf**.) You can also call **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**.

Services associated with clinical trials exclusions

When you're in a clinical research study, neither Medicare nor our plan will pay for any of the following:

- The investigational service
- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study

- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan
- Items and services provided by the research sponsors free of charge for people in the trial

Skilled Nursing Facility Care

Inside our Service Area, we cover skilled inpatient Services in a Plan Skilled Nursing Facility and in accord with Medicare guidelines. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment in accord with our prior authorization procedure if Skilled Nursing Facilities ordinarily furnish the equipment (refer to "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)
- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Whole blood, red blood cells, plasma, platelets, and their administration
- Medical supplies
- Physical, occupational, and speech therapy in accord with Medicare guidelines
- Respiratory therapy

Non–Plan Skilled Nursing Facility care

Generally, you get Skilled Nursing Facility care from Plan Facilities. Under certain conditions listed below, you may be able to receive covered care from a non–Plan facility, if the facility accepts our plan's amounts for payment.

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides Skilled Nursing Facility care)
- A Skilled Nursing Facility where your Spouse is living at the time you leave the hospital

Your Cost Share. We cover these Skilled Nursing Facility Services at **no charge**.

For the following Services, refer to these sections

- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

Substance Use Disorder Treatment

We cover Services specified in this "Substance Use Disorder Treatment" section only when the Services are for the preventive, diagnosis, or treatment of Substance Use Disorders. A "Substance Use Disorder" is a condition identified as a "substance use disorder" in the most recently issued edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM").

Outpatient substance use disorder treatment

We cover the following Services for treatment of substance use disorders:

- Day-treatment programs
- Individual and group substance use disorder counseling by a qualified clinician, including a licensed marriage and family therapist (LMFT)
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms

Your Cost Share. You pay the following for these covered Services:

- Individual substance use disorder evaluation and treatment: **no charge**
- Group substance use disorder treatment: **no charge**
- Intensive outpatient and day-treatment programs: **no charge**

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized substance use disorder treatment, the Services are generally and customarily provided by a substance use disorder residential treatment program in a licensed

residential treatment facility, and the Services are above the level of custodial care:

- Individual and group substance use disorder counseling
- Medical services
- Medication monitoring
- Room and board
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section)
- Discharge planning

Your Cost Share. We cover residential substance use disorder treatment Services at **no charge**.

Inpatient detoxification

We cover hospitalization in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Your Cost Share. We cover inpatient detoxification Services at **no charge**.

For the following Services, refer to these sections

- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient self-administered drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Telehealth Visits (refer to "Telehealth Visits")

Telehealth Visits

Telehealth Visits between you and your provider are intended to make it more convenient for you to receive covered Services, when a Plan Provider determines it is medically appropriate for your medical condition. You have the option of receiving these services either through an in-person visit or via telehealth. You may receive covered Services via Telehealth Visits, when available and if the Services would have been covered under this *EOC* if provided in person. If you choose to receive Services via telehealth, then you must use a Plan Provider that currently offers the service via telehealth. We offer the following telehealth Services:

- Telehealth Services for monthly End-Stage Renal Disease--related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the Member's home
- Telehealth Services to diagnose, evaluate or treat symptoms of a stroke, regardless of your location
- Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location
- Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:
  - you have an in-person visit within 6 months prior to your first telehealth visit
  - you have an in-person visit every 12 months while getting these telehealth services
  - exceptions can be made to the above for certain circumstances
- Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers
- Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if:
  - you're not a new patient and
  - the check-in isn't related to an office visit in the past 7 days and
  - the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment
- Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if:
  - you're not a new patient and
  - the evaluation isn't related to an office visit in the past 7 days and
  - the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
- Consultation your doctor has with other doctors by phone, internet, or electronic health record

Your Cost Share. You pay the following types for Telehealth Visits with Primary Care Physicians, Non-Physician Specialists, and Physician Specialists:

- Interactive video visits: **no charge**
- Scheduled telephone visits: **no charge**

Transplant Services

We cover transplants of organs, tissue, or bone marrow in accord with Medicare guidelines and if the Medical Group provides a written referral for care to a transplant facility as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

After the referral to a transplant facility, the following applies:

- If either the Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover Services you receive before that determination is made
- Health Plan, Plan Hospitals, the Medical Group, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with our guidelines for Services for living transplant donors, we provide certain donation-related Services for a donor, or an individual identified by the Medical Group as a potential donor, whether or not the donor is a Member. These Services must be directly related to a covered transplant for you, which may include certain Services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Please call Member Services for questions about donor Services

Your Cost Share. For covered transplant Services that you receive, you will pay the **Cost Share you would pay if the Services were not related to a transplant**. For example, see "Hospital Inpatient Services" in this "Benefits and Your Cost Share" section for the Cost Share that applies for hospital inpatient Services.

We provide or pay for donation-related Services for actual or potential donors (whether or not they are Members) in accord with our guidelines for donor Services at **no charge**.

For the following Services, refer to these sections

- Dental Services that are Medically Necessary to prepare for a transplant (refer to "Dental Services")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Vision Services

We cover the following:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses: **no charge**
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **no charge**
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **no charge**

Optical Services

We cover the Services described in this "Optical Services" section when received from Plan Medical Offices or Plan Optical Sales Offices.

The date we provide an Allowance toward (or otherwise cover) an item described in this "Optical Services" section is the date on which you order the item. For example, if we last provided an Allowance toward an item you ordered on May 1, 2024, and if we provide an Allowance not more than once every 24 months for that type of item, then we would not provide another Allowance toward that type of item until on or after May 1, 2026. You can use the Allowances under this "Optical Services" section only when you first order an item. If you use part but not all of an Allowance when you first order an item, you cannot use the rest of that Allowance later.

Eyeglasses and contact lenses following cataract surgery

We cover at **no charge** one pair of eyeglasses or contact lenses (including fitting or dispensing) following each cataract surgery that includes insertion of an intraocular lens at Plan Medical Offices or Plan Optical Sales Offices when prescribed by a physician or optometrist. When multiple cataract surgeries are needed, and you do not obtain eyeglasses or contact lenses between procedures, we will only cover one pair of eyeglasses or contact lenses after any surgery. If the eyewear you purchase costs more than what Medicare covers for someone who has Original Medicare (also known as "Fee-for-Service Medicare"), you pay the difference.

Special contact lenses
We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist: **no charge**
- In accord with Medicare guidelines, we cover corrective lenses (including contact lens fitting and dispensing) and frames (and replacements) for Members who are aphakic (for example, who have had a cataract removed but don't have an implanted intraocular lens (IOL) or who have congenital absence of the lens): **no charge**
- For other specialty contact lenses that will provide a significant improvement in your vision not obtainable with eyeglass lenses, we cover either one pair of contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses (up to six months, including fitting and dispensing) in any 24 months at **no charge**

Eyeglasses and contact lenses
We provide a single **$350 allowance** toward the purchase price of any or all of the following not more than once every 24 months when a physician or optometrist prescribes an eyeglass lens (for eyeglass lenses and frames) or contact lens (for contact lenses):

- Eyeglass lenses when a Plan Provider puts the lenses into a frame
  - ♦ we cover a clear balance lens when only one eye needs correction
  - ♦ we cover tinted lenses when Medically Necessary to treat macular degeneration or retinitis pigmentosa
- Eyeglass frames when a Plan Provider puts two lenses (at least one of which must have refractive value) into the frame
- Contact lenses, fitting, and dispensing

We will not provide the Allowance if we have provided an Allowance toward (or otherwise covered) eyeglass lenses or frames within the previous 24 months.

Replacement lenses
If you have a change in prescription of at least .50 diopter in one or both eyes within 12 months of the initial point of sale of an eyeglass lens or contact lens that we provided an Allowance toward (or otherwise covered) we'll provide an Allowance toward the purchase price of a replacement item of the same type (eyeglass lens, or contact lens, fitting, and dispensing) for the eye that had the .50 diopter change. The Allowance toward one of these replacement lenses is $30 for a single vision eyeglass lens or for a contact lens (including fitting and dispensing) and $45 for a multifocal or lenticular eyeglass lens.

Low vision devices
If a low vision device will provide a significant improvement in your vision not obtainable with eyeglasses or contact lenses (or with a combination of eyeglasses and contact lenses), we cover low vision devices (including fitting and dispensing) at **no charge** up to a benefit limit of **$500** every 24 months (including low vision devices we provided an Allowance toward, or otherwise covered, under any other evidence of coverage offered by your Group) when prescribed by a Plan Physician or Plan Optometrist. We will calculate accumulation toward the benefit limit by adding up the Charges for the low vision devices (including fitting and dispensing) we provided an Allowance toward (or otherwise covered) during the previous 24 months, less any amounts (other than deductible payments) that you paid for those devices.

For the following Services, refer to these sections

- Services related to the eye or vision other than Services covered under this "Vision Services" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits and Your Cost Share" section)

Vision Services exclusions

- Eyeglass or contact lens adornment, such as engraving, faceting, or jeweling
- Items that do not require a prescription by law (other than eyeglass frames), such as eyeglass holders, eyeglass cases, and repair kits
- Lenses and sunglasses without refractive value, except as described in this "Vision Services" section
- Replacement of lost, broken, or damaged contact lenses, eyeglass lenses, and frames

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to

all Services that would otherwise be covered under this *EOC* regardless of whether the services are within the scope of a provider's license or certificate. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in this *EOC*. These exclusions or limitations do not apply to Services that are Medically Necessary to treat Severe Mental Illness or Serious Emotional Disturbance of a Child Under Age 18.

Certain exams and Services

Routine physical exams and other Services that are not Medically Necessary, such as when required (1) for obtaining or maintaining employment or participation in employee programs, (2) for insurance, credentialing or licensing, (3) for travel, or (4) by court order or for parole or probation.

Chiropractic Services

Chiropractic Services and the Services of a chiropractor, except for manual manipulation of the spine as described under "Outpatient Care" in the "Benefits and Your Cost Share" section or unless you have coverage for supplemental chiropractic Services as described in an amendment to this *EOC*.

Cosmetic Services

Services that are intended primarily to change or maintain your appearance, including cosmetic surgery (surgery that is performed to alter or reshape normal structures of the body in order to improve appearance), except that this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "Benefits and Your Cost Share" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "Benefits and Your Cost Share" section: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after removal of all or part of a breast or lumpectomy, and prostheses to replace all or part of an external facial body part

Custodial care

Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion doesn't apply to assistance with activities of daily living that is provided as part of covered hospice for Members who do not have Part A, Skilled Nursing Facility, or hospital inpatient care.

Dental care

Dental care and dental X-rays, such as dental Services following accidental injury to teeth, dental appliances, dental implants, orthodontia, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment, except for Services covered in accord with Medicare guidelines or under "Dental Services" in the "Benefits and Your Cost Share" section.

Disposable supplies

Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies.

This exclusion does not apply to disposable supplies covered in accord with Medicare guidelines or under "Durable Medical Equipment ("DME") for Home Use," "Home Health Care," "Hospice Care," "Ostomy, Urological, and Wound Care Supplies," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Prosthetic and Orthotic Devices" in the "Benefits and Your Cost Share" section.

Experimental or investigational Services

A Service is experimental or investigational if we, in consultation with the Medical Group, determine that one of the following is true:

- Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients)
- It requires government approval that has not been obtained when the Service is to be provided

Hair loss or growth treatment

Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Durable Medical Equipment ("DME") for Home Use," "Home Health Care," and "Hospice Care" in the "Benefits and Your Cost Share" section.

Items and services that are not health care items and services

For example, we do not cover:

- Teaching manners and etiquette

- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services for the purpose of increasing academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play, or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy, except when ordered as part of a physical therapy program in accord with Medicare guidelines

Items and services to correct refractive defects of the eye

Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism.

Massage therapy

Massage therapy, and services of massage therapists.

Oral nutrition and weight loss aids

Outpatient oral nutrition, such as dietary supplements, herbal supplements, formulas, food, and weight loss aids.

This exclusion does not apply to any of the following:

- Amino acid–modified products and elemental dietary enteral formula covered under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section
- Enteral formula covered under "Prosthetic and Orthotic Devices" in the "Benefits and Your Cost Share" section

Residential care

Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a Skilled Nursing Facility, inpatient respite care covered in the "Hospice Care" section for Members who do not have Part A, or residential treatment program Services covered in the "Substance Use Disorder Treatment" and "Mental Health Services" sections.

Routine foot care items and services

Routine foot care items and services, except for Medically Necessary Services covered in accord with Medicare guidelines.

Services not approved by the federal Food and Drug Administration

Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other Services that by law require federal Food and Drug Administration ("FDA") approval in order to be sold in the U.S., but are not approved by the FDA. This exclusion applies to Services provided anywhere, even outside the U.S., unless the Services are covered under the "Emergency Services and Urgent Care" section.

This exclusion does not apply to COVID-19 Services granted emergency use authorization by the FDA (COVID-19 laboratory tests, therapeutics, and immunizations must be prescribed or furnished by a licensed health care provider acting within their scope of practice and the standard of care).

Services and items not covered by Medicare

Services and items that are not covered by Medicare, including services and items that aren't reasonable and necessary, according to the standards of the Original Medicare plan, unless these Services are otherwise listed in this *EOC* as a covered Service.

Services performed by unlicensed people

Services that are performed safely and effectively by people who don't require licenses or certificates by the state to provide health care services and where the Member's condition doesn't require that the services be provided by a licensed health care provider.

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services we would otherwise cover to treat complications of the noncovered Service or if covered in accord with Medicare guidelines. For example, if you have a noncovered cosmetic surgery, we would not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and we would cover any Services that we would otherwise cover to treat that complication.

Surrogacy

Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. Refer to "Surrogacy Arrangements" under "Reductions" in this "Exclusions, Limitations, Coordination of Benefits, and Reductions" section for information about your obligations to us in connection with a Surrogacy Arrangement, including your obligations to reimburse us for any Services we cover and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.

Travel and lodging expenses

Travel and lodging expenses, except as described in our Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at **kp.org/specialty-care/travel-reimbursements** or by calling Member Services.

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC*, such as a major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor dispute. Under these circumstances, if you have an Emergency Medical Condition, call 911 or go to the nearest Emergency Department as described under "Emergency Services" in the "Emergency Services and Urgent Care" section, and we will provide coverage and reimbursement as described in that section.

Additional limitations that apply only to a particular benefit are listed in the description of that benefit in this *EOC*.

Coordination of Benefits

If you have other medical or dental coverage besides your Group's non-Medicare plan, it is important to use your other coverage in combination with your coverage as a Senior Advantage Member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

You must tell us if you have other health care coverage, in addition to your Group's non-Medicare plan, and let us know whenever there are any changes in your additional coverage. The types of additional coverage that you might have include the following:

- Coverage that you have from another employer's group health care coverage for employees or retirees, either through yourself or your spouse
- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program
- Coverage you have for an accident where no-fault insurance or liability insurance is involved
- Coverage you have through Medicaid
- Coverage you have through the "TRICARE for Life" program (veteran's benefits)
- Coverage you have for dental insurance or prescription drugs
- "Continuation coverage" you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions)

When you have additional health care coverage besides your Group's non-Medicare plan, how we coordinate your benefits as a Senior Advantage Member with your benefits from your other coverage depends on your situation. With coordination of benefits, you will often get your care as usual from Plan Providers, and the other coverage you have will simply help pay for the care you receive. In other situations, such as benefits that we don't cover, you may get your care outside of our plan directly through your other coverage.

In general, the coverage that pays its share of your bills first is called the "primary payer." Then the other company or companies that are involved (called the "secondary payers") each pay their share of what is left of your bills. Often your other coverage will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this payment to us. When you have additional coverage, whether we pay first or second, or at all, depends on what type or types of additional coverage you have and the rules that apply to your situation. Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have End-Stage Renal Disease, or how many employees are covered by an employer's group plan.

If you have additional health coverage besides your Group's non-Medicare plan, please call Member Services to find out which rules apply to your situation, and how payment will be handled.

Reductions

Employer responsibility

For any Services that the law requires an employer to provide, we will not pay the employer, and, when we cover any such Services, we may recover the value of the Services from the employer.

Government agency responsibility

For any Services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and, when we cover any such Services, we may recover the value of the Services from the government agency.

Injuries or illnesses alleged to be caused by third parties

Third parties who cause you injury or illness (and/or their insurance companies) usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue these primary payments. If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered Services, you must ensure we receive reimbursement for those Services. Note: This "Injuries or illnesses alleged to be caused by third parties" section does not affect your obligation to pay your Cost Share for these Services.

To the extent permitted or required by law, we shall be subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain against a third party that results in any settlement proceeds or judgment, from other types of coverage that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, workers' compensation, personal injury, medical payments and all other first party types. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether you are made whole and regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred. We are not required to pay attorney fees or costs to any attorney hired by you to pursue your damages claim. If you reimburse us without the need for legal action, we will allow a procurement cost discount. If we have to pursue legal action to enforce its interest, there will be no procurement discount.

Within 30 days after submitting or filing a claim or legal action against a third party, you must send written notice of the claim or legal action to:

The Rawlings Company
One Eden Parkway
P.O. Box 2000
LaGrange, KY 40031-2000
Fax: 1-502-753-7064
Email:
ManualFileCoordinator@rawlingscompany.com

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on your injury or illness, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

Surrogacy Arrangements

If you enter into a Surrogacy Arrangement and you or any other payee are entitled to receive monetary compensation under the Surrogacy Arrangement, you must reimburse us for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services") to the maximum extent allowed under California Civil Code Section 3040. Note: This "Surrogacy Arrangements" section does not affect your obligation to pay your Cost Share for these Services. After you surrender a baby to the legal parents, you are not obligated to reimburse us for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and phone numbers of the other parties to the arrangement
- Names, addresses, and phone numbers of any escrow agent or trustee
- Names, addresses, and phone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receive, including names, addresses, and phone numbers for any health insurance that will cover Services that the baby (or babies) receive
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

The Rawlings Company
One Eden Parkway
P.O. Box 2000
LaGrange, KY 40031-2000
Fax: 1-502-753-7064

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy Arrangements" section and to satisfy those rights. You may not agree to waive, release, or reduce our rights under this "Surrogacy Arrangements" section without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against another party based on the Surrogacy Arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the other party. We may assign our rights to enforce our liens and other rights.

If you have questions about your obligations under this provision, please call Member Services.

U.S. Department of Veterans Affairs

For any Services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs, and when we cover any such Services we may recover the value of the Services from the Department of Veterans Affairs.

Workers' compensation or employer's liability benefits

Workers' compensation usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue primary payments under workers' compensation or employer's liability law. You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered Services from the following sources:

- From any source providing a Financial Benefit or from whom a Financial Benefit is due
- From you, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law

Requests for Payment

Asking Us to Pay Our Share of a Bill for Covered Medical Services or Drugs

Situations when you should ask us to pay our share for covered Services or drugs

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may find you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of

the cost for medical services or drugs covered by our plan. There may be deadlines that you must meet to get paid back.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost sharing. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted, you still have the right to treatment.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

When you got emergency, urgently needed medical care from a Non–Plan Provider. Outside the service area, you can get emergency or urgently needed services from any provider, whether or not the provider is a Plan Provider. In these cases:

- You're only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care. If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made
- You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made
  - ♦ if the provider is owed anything, we'll pay the provider directly
  - ♦ if you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost

When a Plan Provider sends you a bill you think you shouldn't pay. Plan Providers should always bill our plan directly and ask you only for your share of the cost. But sometimes they make mistakes and ask you to pay more than your share.

- You only have to pay your Cost Share amount when you get covered Services. We don't allow providers to add additional separate charges, called balance billing. This protection (that you never pay more than your Cost Share amount) applies even if we pay the provider less than the provider charges for a service, and even if there's a dispute and we don't pay certain provider charges
- Whenever you get a bill from a Plan Provider you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem
- If you already paid a bill to a Plan Provider, but feel you paid too much, send us the bill along with documentation of any payment you made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan

If you're retroactively enrolled in our plan. Sometimes a person's enrollment in our plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.) If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered Services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork, such as receipts and bills for us to handle the reimbursement.

When you use a Non–Plan Pharmacy to fill a prescription. If you go to a Non-Plan Pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover non-plan pharmacies in limited circumstances. Go to the "Outpatient Prescription Drugs, Supplies, and Supplements" section to learn about these circumstances. We may not pay you back the difference between what you paid for the drug at the Non-Plan Pharmacy and the amount we'd pay at a Plan Pharmacy.

When you pay the full cost for a prescription because you don't have our plan membership card with you. If you don't have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

When you pay the full cost for a prescription in other situations. You may pay the full cost of the prescription because you find the drug isn't covered for some reason.

- For example, the drug may not be on our plan's Drug List, or it could have a requirement or restriction you

didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it

- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. The "Coverage Decisions, Appeals, and Complaints" section has information about how to make an appeal.

How to Ask Us to Pay You Back or Pay a Bill You Got

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. You must submit your claim to us within 12 months (for Part C medical claims) and within 36 months (for Part D drug claims) of the date you got the service, item, or drug.

To make sure you're giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment. You don't have to use the form, but it will help us process the information faster. You can file a claim to request payment by:

- Completing and submitting our electronic form at **kp.org** and upload supporting documentation
- Either download a copy of the form from our website **kp.org** or call Member Services and ask them to send you the form. Mail the completed form to our Claims Department address listed below
- If you're unable to get the form, you can file your request for payment by sending us the following information to our Claims Department address listed below:
  - ♦ a statement with the following information:
    - – your name (member/patient name) and medical/health record number
    - – the date you received the services
    - – where you received the services
    - – who provided the services
    - – why you think we should pay for the services
    - – your signature and date signed. (If you want someone other than yourself to make the request, we'll also need a completed "Appointment of Representative" form, which is available at **kp.org**)
  - ♦ a copy of the bill, your medical record(s) for these services, and your receipt if you paid for the services
- Mail your request for payment of medical care together with any bills or paid receipts to us at this address:
  Kaiser Permanente
  Claims Department
  P.O. Box 7004
  Downey, CA 90242-7004

To request payment of a Part D drug that was prescribed by a Plan Provider and obtained from a Plan Pharmacy, write to the address below. For all other Part D requests, send your request to the address above.

Kaiser Permanente
Medicare Part D Unit
P.O. Box 1809
Pleasanton, CA 94566

We'll Consider Your Request for Payment and Say *Yes* or *No*

When we get your request for payment, we'll let you know if we need any additional information from you. Otherwise, we'll consider your request and make a coverage decision.

- If we decide the medical care or drug is covered and you followed all the rules, we'll pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you got a drug at a Non-Plan Pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you already paid for the service or drug, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider
- If we decide the medical care or drug is not covered, or you did not follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your right to appeal that decision

If we tell you that we won't pay for all or part of the medical care or drug, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment.

The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to the "Coverage Decisions, Appeals, and Complaints" section.

Your Rights and Responsibilities

Our plan must honor your rights and cultural sensitivities

We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, large font, braille, audio file, or data CD)

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan can meet these accessibility requirements include but aren't limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English-speaking members. We can also give you information in languages other than English including Spanish, and large font, braille, audio file, or data CD at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at **1-800-443-0815** (TTY users call **711**).

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost-sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go to get this service at in-network cost-sharing.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Member Services. You can also file a complaint with Medicare by calling **1-800-MEDICARE** (**1-800-633-4227**) or directly with the Office for Civil Rights **1-800-368-1019** or TTY **1-800-537-7697**.

Debemos proporcionar la información de un modo adecuado para usted y que sea coherente con sus sensibilidades culturales (en idiomas distintos al inglés, en letra grande, en braille, en archivo de audio o en CD de datos)

Nuestro plan está obligado a garantizar que todos los servicios, tanto clínicos como no clínicos, se brinden de manera culturalmente competente y sean accesibles para todos los inscritos, incluidos aquellos con habilidades de lectura y dominio del inglés limitadas, discapacidad auditiva o a los miembros de diversos orígenes étnicos y culturales. Algunos ejemplos de cómo nuestro plan puede cumplir estos requisitos de accesibilidad incluyen, entre otros, proporcionar servicios de traducción, servicios de interpretación, de teletipo o TTY (teléfono de texto o teletipo).

Nuestro plan tiene servicios de interpretación disponibles sin costo para responder las preguntas de los miembros que no hablan inglés. Este documento está disponible en idiomas que no son inglés, incluso en español y, si lo necesita, en letra grande, braille, archivo de audio o CD de datos sin ningún costo. Tenemos la obligación de darle información acerca de los beneficios de nuestro plan en un formato que sea accesible y adecuado para usted. Para obtener información de una forma que se adapte a sus necesidades, llame a Servicio a los Miembros al **1-800-443-0815** (si es usuario de TTY, llame al **711**).

Nuestro plan está obligado a ofrecer a las mujeres inscritas la opción de acceder directamente a un especialista en salud de la mujer dentro de la red para los servicios de atención médica preventiva y de rutina para la mujer.

Si los proveedores de la red de nuestro plan para una especialidad no están disponibles, es responsabilidad de nuestro plan buscar proveedores fuera de la red que le proporcionen la atención necesaria. En este caso, usted solo pagará el costo compartido dentro de la red. Si se encuentra en una situación en la que no hay especialistas

dentro de la red de nuestro plan que cubran el servicio que necesita, llame a nuestro plan para recibir información sobre a dónde acudir para obtener este servicio con un costo compartido dentro de la red.

Si tiene algún problema para obtener información de nuestro plan en un formato que sea accesible y adecuado para usted, para ver a un especialista en salud de la mujer o para encontrar un especialista de la red, llame a Servicio a los Miembros para presentar una queja formal al **1-800-443-0815** (si es usuario de TTY, llame al **711**). También puede presentar una queja informal en Medicare llamando al **1-800-MEDICARE** (**1-800-633-4227**) o directamente con la Oficina de Derechos Civiles al **1-800-368-1019** o al TTY **1-800-537-7697**.

We must ensure you get timely access to covered Services and drugs

You have the right to choose a primary care provider (PCP) in our plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist, a mental health services provider, and an optometrist) without a referral, as well as other providers described in the "How to Obtain Services" section.

You have the right to get appointments and covered services from our plan's network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think you aren't getting your medical care or drugs within a reasonable amount of time, "How to make a complaint about quality of care, waiting times, customer service, or other concerns" in the "Coverage Decisions, Appeals, and Complaints" section tells what you can do.

We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a Notice of Privacy Practices, that tells about these rights and explains how we protect the privacy of your health information

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you or someone you have given legal power to make decisions for you first
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law
  - ♦ we're required to release health information to government agencies that are checking on quality of care
  - ♦ because you're a Member of our plan through Medicare, we're required to give Medicare your health information, including information about your Part D drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared
- Your health information is shared with your Group only with your authorization or as otherwise permitted by law

You can see the information in your records and know how it's been shared with others

You have the right to look at your medical records held by our plan, and to get a copy of your records. We're allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we'll work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your personal health information, call Member Services.

We must give you information about our plan, our Plan Providers, and your covered services

As a Member of our plan, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Member Services:

- **Information about our plan.** This includes, for example, information about our plan's financial condition
- **Information about our network providers and pharmacies**
  - ♦ you have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network
- **Information about your coverage and the rules you must follow when using your coverage**
  - ♦ the "How to Obtain Services" and "Benefits and Your Cost Share" sections provide information regarding medical Services
  - ♦ the "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section provides information about drug coverage
- **Information about why something is not covered and what you can do about it**
  - ♦ the "Coverage Decisions, Appeals, and Complaints" section provides information on asking for a written explanation on why a medical service or drug isn't covered, or if your coverage is restricted
  - ♦ the "Coverage Decisions, Appeals, and Complaints" section also provides information on asking us to change a decision, also called an appeal

You have the right to know your treatment options and participate in decisions about your care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. If you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you're in this situation. This means, if you want to, you can:

- Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself
- Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself

Legal documents you can use to give directions in advance of these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form**. You can get an advance directive, a form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Member Services to ask for the forms
- **Fill out the form and sign it**. No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home

If you know ahead of time that you're going to be hospitalized, and you signed an advance directive, take a copy with you to the hospital.

- The hospital will ask whether you signed an advance directive form and whether you have it with you
- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one

Filling out an advance directive is your choice (including whether you want to sign one if you're in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you signed an advance directive.

If your instructions aren't followed
If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the Quality Improvement Organization listed in the "Phone Numbers and Resources" section.

You have the right to make complaints and ask us to reconsider decisions we made

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, the "Coverage Decisions, Appeals, and Complaints" section of this document tells what you can do. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—**we're required to treat you fairly**.

If you believe you're being treated unfairly, or your rights aren't being respected

If you believe you've been treated unfairly, your dignity has not been recognized, or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' Office for Civil Rights at **1-800-368-1019** (TTY users call **1-800-537-7697)**, or call your local Office for Civil Rights.

If you believe you've been treated unfairly or your rights haven't been respected, and it's not about discrimination, you can get help dealing with the problem you're having from these places:

- **Call Member Services** at **1-800-443-0815** (TTY users call **711**)
- **Call your local SHIP** at **1-800-434-0222**
- **Call Medicare** at **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**)

How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services** at **1-800-443-0815** (TTY users call **711**)
- **Call your local SHIP** at **1-800-434-0222**
- **Contact Medicare:**
  - visit **www.Medicare.gov** to read the publication Medicare Rights & Protections. (available at **https://www.Medicare.gov/publications/11534-medicare-rights-and-protections.pdf**)
  - call **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**)

Information about new technology assessments

Rapidly changing technology affects health care and medicine as much as any other industry. To determine whether a new drug or other medical development has long-term benefits, our plan carefully monitors and evaluates new technologies for inclusion as covered benefits. These technologies include medical procedures, medical devices, and new drugs.

You can make suggestions about rights and responsibilities

As a Member of our plan, you have the right to make recommendations about the rights and responsibilities included in this section. Please call Member Services with any suggestions.

Your responsibilities as a Member of our plan

Things you need to do as a Member of our plan are listed below. For questions, call Member Services.

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this *EOC* to learn what's covered and the rules you need to follow to get covered services
  - the "How to Obtain Services" and "Benefits and Your Cost Share" sections give details about medical services
  - the "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section give details about drug coverage
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us**.
  - the "Exclusion, Limitations, Coordination of Benefits, and Reductions" section tells you about coordinating these benefits
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care or drugs

- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care**
  - ♦ to help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on
  - ♦ make sure you understand your health problems and participate developing mutually agreed upon treatment goals with your providers whenever possible
  - ♦ make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements
  - ♦ if you have questions, be sure to ask and get an answer you can understand
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - ♦ you must continue to pay a premium for your Medicare Part B to stay a Member of our plan
  - ♦ for most of your medical Services or drugs covered by our plan, you must pay your share of the cost when you get the Service or drug
  - ♦ if you're required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to stay a Member of our plan
- **If you move within your Home Region Service Area**, we need to know so we can keep your membership record up to date and know how to contact you
- **If you move outside our Service Area**, you can't stay a member of our plan
- If you move, tell Social Security (or the Railroad Retirement Board)

Coverage Decisions, Appeals, and Complaints

What to Do if You Have a Problem or Concern

This section explains 2 types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals**
- For other problems, you need to use the **process for making complaints** (also called grievances)

Both processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The information in this "Coverage Decisions, Appeals, and Complaints" section will help you identify the right process to use and what to do.

This section describes the procedures under this Senior Advantage *EOC* when Medicare is secondary. You must refer to your non-Medicare plan document which provides your primary Group coverage for the dispute resolution procedures applicable to your non-Medicare plan.

Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this "Coverage Decisions, Appeals, and Complaints" section. Many of these terms are unfamiliar to most people. To make things easier, this section uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

Where To Get More Information and Personalized Help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help you are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You can contact HICAP (California's SHIP) at **1-800-434-0222** (TTY **711**).

Medicare

You can also contact Medicare for help.

- Call **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**
- Visit **www.Medicare.gov**

Which Process to Use for Your Problem

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they are covered, and problems related to payment for medical care.

- **Yes**. Go to "A Guide to Coverage Decisions and Appeals"
- **No**. Go to "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns"

A Guide to Coverage Decisions and Appeals

Coverage decisions and appeals deal with problems about your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not, and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our Plan Physician refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your Plan Physician can show that you got a standard denial notice for this medical specialist, or the *EOC* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision, if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.

In limited circumstances, a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances, a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go to a Level 2 appeal conducted by an independent review organization that is not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal
- Go to "The Level 2 appeal process" for more information about Level 2 appeals for medical care
- Part D appeals are discussed further in "Part D Drugs: How to Ask for a Coverage Decision or Make an Appeal"

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this section explains the Level 3, 4, and 5 appeals processes).

Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call Member Services**
- **Get free help** from your State Health Insurance Assistance Program
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services and ask for the Appointment of Representative form. (The form is also available at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **kp.org**)
  - for medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2
  - for Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal
  - if you want a friend, relative, or other person to be your representative, call Member Services and ask for the Appointment of Representative form. (The form is also available at **https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **kp.org**.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form
  - we can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal
- **You also have the right to hire a lawyer.** You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision

Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations:

- "Medical Care: How to Ask for a Coverage Decision or Make an Appeal"
- "Part D Drugs: How to Ask for a Coverage Decision or Make an Appeal"
- "How to Ask Us to Cover a Longer Inpatient Hospital Stay if You Think You're Being Discharged Too Soon"
- "How to Ask Us to Keep Covering Certain Medical Services if You Think Your Coverage is Ending Too Soon" (applies only to these services: home health care, Skilled Nursing Facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Member Services. You can also get help or information from your SHIP.

Medical Care: How to Ask for a Coverage Decision or Make an Appeal

What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in the "Benefits and Your Cost Share" section. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the five following situations:

- You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision**
- Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision**
- You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an appeal**
- You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill**
- You're told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal**

Note: If the coverage that will be stopped is for hospital care, home health care, Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to "How to Ask Us to Cover a Longer Inpatient Hospital Stay if You Think the Doctor Is Discharging You Too Soon" and "How to Ask Us to Keep Covering Certain Medical Services if You Think Your Coverage is Ending Too Soon". Special rules apply to these types of care.

How to ask for a coverage decision

A coverage decision that involves your medical care, is called an **organization determination**. A fast coverage decision is called an **expedited determination**.

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

- you may only ask for coverage for medical items and/or services (not requests for payment for items and/or services you already got)
- you can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to regain function

If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision

If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- explains that we'll use the standard deadlines
- explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision
- explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for

Step 2: Ask our plan to make a coverage decision or fast coverage decision

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. The "Phone Numbers and Resources" section has contact information

Step 3: We consider your request for medical care coverage and give you our answer

For standard coverage decisions, we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **however**, if you ask for more time, or if we need more information that may benefit you, **we can**

take up to 14 more calendar days if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug

- if you believe we shouldn't take extra days, you can file a fast complaint. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" for information on complaints.)

For fast coverage decisions, we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **however**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug
- if you believe we shouldn't take extra days, you can file a fast complaint. Go to "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" for information on complaints.) We'll call you as soon as we make the decision
- if our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no

Step 4: If we say no to your request for coverage for medical care, you can appeal

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process

How to make a Level 1 appeal

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration**. A fast appeal is also called an **expedited reconsideration**.

Step 1: Decide if you need a standard appeal or a fast appeal

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in "Medical Care: How to Ask for a Coverage Decision or Make an Appeal"

Step 2: Ask our plan for an appeal or a fast appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing**. The "Phone Numbers and Resources" section has contact information
- **If you're asking for a fast appeal, make your appeal in writing or call us**. The "Phone Numbers and Resources" section has contact information
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal**. We're allowed to charge a fee for copying and sending this information to you

Step 3: We consider your appeal and we give you our answer

- When our plan is reviewing your appeal, we take a careful look at all the information. We check to see if we followed all the rules when we said no to your request
- We'll gather more information if needed and may contact you or your doctor

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to
  - if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug
  - if we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. "The Level 2 Appeal Process" explains the Level 2 appeal process
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal
- **If our answer is no to part or all of what you asked for**, we'll automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we receive your appeal. We'll give you our decision sooner if your health condition requires us to
  - if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug
  - if you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this section for information on complaints)
  - if we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. Later in this section, we explain the Level 2 appeal process
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug
- **If our plan says no to part or all of what your appeal**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal

The Level 2 appeal process

The formal name for the independent review organization is the **Independent Review Entity**. It's sometimes called the **IRE**.

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We're allowed to charge you a fee for copying and sending this information to you
- You have a right to give the independent review organization additional information to support your appeal
- Reviewers at the independent review organization will take a careful look at all the information about your appeal

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2

appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal

- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug

Step 2: The independent review organization gives you its answer

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage **within 72 hours** or provide the service **within 14 calendar days** after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization
- **If the independent review organization says** yes **to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug **within 72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **24 hours** from the date we get the decision from the independent review organization
- **If this organization says no to part or all of your appeal**, it means it agrees with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:
  - ♦ explains the decision
  - ♦ lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process
  - ♦ tells you how to file a Level 3 appeal

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. "Taking Your Appeal to Level 3 and Beyond" explains the Levels 3, 4, and 5 appeals processes

If you're asking us to pay for our share of a bill you got for medical care

The "Requests for Payment" section describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider
- **If we say no to your request:** If the medical care is not covered, or you did not follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in "How to make a Level 1 Appeal." For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days

Part D Drugs: How to Ask for a Coverage Decision or Make an Appeal

What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books.) For details about Part D drugs, rules, restrictions, and costs go to "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section. **This section is about your Part D drugs only.** To keep things simple, we generally say drug in the rest of this section, instead of repeating covered outpatient prescription drug or Part D drug every time. We also use the term Drug List instead of List of Covered Drugs or 2026 Comprehensive Formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision

Part D coverage decisions and appeals

An initial coverage decision about your Part D drugs is called a **coverage determination**.

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that's not on our 2026 Comprehensive Formulary. **Ask for an exception**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception**
- Asking to get pre-approval for a drug. **Ask for a coverage decision**
- Pay for a prescription drug you already bought. **Ask us to pay you back**

If you disagree with a coverage decision we made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to ask for an appeal.

Asking for an exception

- Asking for coverage of a drug that's not on the Drug List is a formulary exception
- Asking for removal of a restriction on coverage for a drug is a **formulary exception**
- Asking to pay a lower price for a covered non-preferred drug is a **tiering exception**

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

- **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay your Cost Share, which will vary depending on your plan. You can't ask for an exception to the Cost Share we require you to pay for the drug
- **Removing a restriction for a covered drug**. "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the Cost Share we require you to pay for the drug
- **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you pay as your share of the cost of the drug
  - ♦ if our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s)
  - ♦ if the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition

- if the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition
- if the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition
- you can't ask us to change the cost-sharing tier for any drug in Tier 5 (specialty-tier drugs)
- if we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount

Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List typically includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you're asking for and wouldn't cause more side effects or other health problems, we generally won't approve your request for an exception. If you ask us for a tiering exception, we generally won't approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of our plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition
- If we say no to your request, you can ask for another review by making an appeal

How to ask for a coverage decision, including an exception

A fast coverage decision is called an **expedited coverage determination**.

Step 1: Decide if you need a standard coverage decision or a fast coverage decision

Standard coverage decisions are made within **72 hours** after we get your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. To get a fast coverage decision, you must meet 2 requirements:

- You must be asking for a drug you didn't get yet. (You can't ask for a fast coverage decision to be paid back for a drug you have already bought)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision**, we'll automatically give you a fast coverage decision
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
  - explains that we'll use the standard deadlines
  - explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision
  - tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt

Step 2: Ask for a standard coverage decision or a fast coverage decision

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website **kp.org**. The "Phone Numbers and Resources" section has contact information. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

You, or your doctor (or other prescriber), or your representative can do this. You can also have a lawyer act on your behalf. "How to Get Help When You are Asking for a Coverage Decision or Making an Appeal"

tells how you can give written permission to someone else to act as your representative.

- If you're asking for an exception, provide the supporting statement which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary

Step 3: We consider your request and give you our answer

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we get your request
  - for exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to
  - if we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must generally give you our answer **within 72 hours** after we get your request
  - for exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to
  - if we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it'll be reviewed by an independent review organization
- **If our answer is yes to part or all of what you asked for**, we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we get your request
  - if we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization
- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within 14 calendar days after we get your request
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal

Step 4: If we say no to your coverage request, you can make an appeal

If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you're going to Level 1 of the appeals process.

How to make a Level 1 appeal

An appeal to our plan about a Part D drug coverage decision is called a plan **redetermination**. A fast appeal is called an **expedited redetermination**.

Step 1: Decide if you need a standard appeal or a fast appeal

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal

- If you're appealing a decision we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in "How to ask for a coverage decision, including a Part D exception"

Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal

- **For standard appeals, submit a written request**. The "Phone Numbers and Resources" section has contact information

- **For fast appeals either submit your appeal in writing or call Member Services**. The "Phone Numbers and Resources" section has contact information
- **We must accept any written request**, including a request submitted on the CMS Model Redetermination Request Form, which is available on our website **kp.org**. Include your name, contact information, and information about your claim to help us process your request
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal
- **You can ask for a copy of the information in your appeal and add more information**. You and your doctor may add more information to support your appeal. We're allowed to charge a fee for copying and sending this information to you

Step 3: We consider your appeal and give you our answer

- When we review your appeal, we take another careful look at all the information about your coverage request. We check to see if we were following all the rules when we said ***no*** to your request. We may contact you or your doctor or other prescriber to get more information

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to
  - ♦ if we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. "How to make a Level 2 appeal" explains the Level 2 appeal process
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 72 hours after we get your appeal
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so
  - ♦ if we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. "How to make a Level 2 appeal" explains the Level 2 appeal process
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision

Deadlines for a standard appeal about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request
  - ♦ if we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization
- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within 30 calendar days after we get your request
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal our decision

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process

How to make a Level 2 appeal

The formal name for the independent review organization is the **Independent Review Entity**. It is sometimes called the **IRE**.

The independent review organization is an independent organization hired by Medicare. It is not connected with us and is not a government agency. This organization decides whether the decision we made is

correct or if it should be changed. Medicare oversees its work.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.
  - **you must make your appeal request within 65 calendar days** from the date on the written notice
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE
- We'll send the information about your appeal to the independent review organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We're allowed to charge you a fee for copying and sending this information to you
- You have a right to give the independent review organization additional information to support your appeal

Step 2: The independent review organization reviews your appeal

Reviewers at the independent review organization will take a careful look at all the information about your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request

Step 3: The independent review organization gives you its answer

For fast appeals:

- **If the independent review organization says yes to part or all of what you asked for**, we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we get the decision from the independent review organization

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage**, we must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we get the decision from the independent review organization
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we're required to **send payment to you** within 30 calendar days after we get the decision from the independent review organization

What if the independent review organization says *no* to your appeal?

If this organization says no to **part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It's also called **turning down your appeal**.) In this case, the independent review organization will send you a letter that:

- Explains the decision
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final
- Tells you the dollar value that must be in dispute to continue with the appeals process

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal)

- If you want to go on to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. "Taking Your Appeal to Level 3 and Beyond" tells more about Levels 3, 4, and 5 of the appeals process

How to Ask Us to Cover a Longer Inpatient Hospital Stay if You Think You're Being Discharged Too Soon

When you're admitted to a hospital, you have the right to get all covered hospital Services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**
- When your discharge date is decided, your doctor or the hospital staff will tell you
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered

During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services or **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**).

- **Read this notice carefully and ask questions if you don't understand it.** It tells you:
  - your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them
  - your right to be involved in any decisions about your hospital stay
  - where to report any concerns you have about the quality of your hospital care
  - your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so we'll cover your hospital care for a longer time
- **You'll be asked to sign the written notice to show that you got it and understand your rights**
  - you or someone who is acting on your behalf will be asked to sign the notice
  - signing the notice shows only that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date
- **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it
  - if you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged
  - to look at a copy of this notice in advance, call Member Services or **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**. You can also get the notice online at **www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im**

How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Member Services. Or call your State Health Insurance Assistance Program (SHIP) for personalized help. California's SHIP is known as the Health Insurance Counseling and Advocacy Program (**www.aging.ca.gov/HICAP/**). SHIP contact information is available in the "Phone Numbers and Resources" section

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes

reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly

How can you contact this organization?

- The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in the "Phone Numbers and Resources" section

Act quickly

- To make your appeal, you must contact the Quality Improvement Organization **before** you leave the hospital and **no later than midnight the day of your discharge**
  - **if you meet this deadline**, you can stay in the hospital after your discharge date without paying for it while you wait to get the decision from the Quality Improvement Organization
  - **if you don't meet this deadline, contact us**. If you decide to stay in the hospital after your planned discharge date, you may have to pay the costs for hospital care you get after your planned discharge date

Once you ask for an immediate review of your hospital discharge, the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling Member Services or **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**. Or you can get a sample notice online at **www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im**.

Step 2: The Quality Improvement Organization conducts an independent review of your case

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal

What happens if the answer is yes?

- If the independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary**
- You'll have to keep paying your share of the costs (such as Cost Share, if applicable). In addition, there may be limitations on your covered hospital services

What happens if the answer is no?

- If the independent review organization says *no*, they're saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal
- If the independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal

- If the Quality Improvement Organization said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you are going on to *Level 2* of the appeals process

How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said no to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date your coverage for the care ended

Step 2: The Quality Improvement Organization does a second review of your situation

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information about your appeal

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you its decision

If the independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary**
- You must continue to pay your share of the costs, and coverage limitations may apply

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called upholding the decision
- The notice you get will tell you in writing what you can do if you want to continue with the review process

Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. The "Taking Your Appeal to Level 3 and Beyond" section tells more about Levels 3, 4, and 5 of the appeals process

How to Ask Us to Keep Covering Certain Medical Services if You Think Your Coverage Is Ending Too Soon

When you're getting covered **home health services, Skilled Nursing Facility care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

We'll tell you in advance when your coverage will be ending

The **Notice of Medicare Non-Coverage** tells how you can ask for a **fast-track appeal**. Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

- **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
  - the date when we'll stop covering the care for you
  - how to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time
- **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got.** Signing the notice shows *only* that you have got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care

How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you'll need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it**. If you have questions or need help, call Member Services. Or call your State Health Insurance Assistance Program (SHIP) for personalized help. California's SHIP is known as the Health Insurance Counseling and Advocacy Program (**www.aging.ca.gov/HICAP/**). SHIP contact

information is available in the "Phone Numbers and Resources" section

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in the "Phone Numbers and Resources" section

Act quickly

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the *Notice of Medicare Non-Coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in the "Phone Numbers and Resources" section

Step 2: The Quality Improvement Organization conducts an independent review of your case

The **Detailed Explanation of Non-Coverage** gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you or your representative why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them
- By the end of the day the reviewers tell us of your appeal, you'll get the *Detailed Explanation of Non-Coverage* from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need, the reviewers will tell you its decision

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it's medically necessary**
- You'll have to keep paying your share of the costs (such as Cost Share, if applicable). There may be limitations on your covered services

What happens if the reviewers say no?

- If the reviewers say *no,* then **your coverage will end on the date we told you**
- If you decide to keep getting the home health care, or Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after this date when your coverage ends, **you'll have to pay the full cost** of this care yourself

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal

- If reviewers say *no* to your Level 1 appeal, and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 appeal

How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said **no** to your Level 1 appeal. You can

ask for this review only if you continued getting care after the date your coverage for the care ended

Step 2: The Quality Improvement Organization does a second review of your situation

- Reviewers at the Quality Improvement Organization will take another careful look at all the information about your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you its decision

What happens if the independent review organization says yes?

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary
- You must continue to pay your share of the costs and there may be coverage limitations that apply

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator

Step 4: If the answer is no, you'll need to decide whether you want to take your appeal further

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. "Taking Your Appeal to Level 3 and Beyond" in this "Coverage Decisions, Appeals, and Complaints" section tells more about Levels 3, 4, and 5 of the appeals process

Taking Your Appeal to Levels 3, 4, and 5

Appeal Levels 3, 4, and 5 for Medical Service Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may or may not* be over**. Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal
  - ♦ if we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision
  - ♦ if we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may or may not* be over**
  - ♦ if you decide to accept the decision that turns down your appeal, the appeals process is over
  - ♦ if you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may or may not* be over**. Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5
  - ♦ if we decide *not* to appeal the decision, we must authorize or provide you with the medical care

within 60 calendar days after getting the Council's decision

- ♦ if we decide to appeal the decision, we'll let you know in writing

- **If the answer is no or if the Council denies the review request, the appeals process *may or may not* be over**
  - ♦ if you decide to accept this decision that turns down your appeal, the appeals process is over
  - ♦ if you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal

Level 5 appeal

A judge at the **Federal District Court** will review your appeal

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court

Appeal Levels 3, 4, and 5 for Part D Drug Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the value of the Part D drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision
- **If the answer is no, the appeals process *may or may not* be over**
  - ♦ If you decide to accept the decision that turns down your appeal, the appeals process is over
  - ♦ If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision
- **If the answer is no, the appeals process *may or may not* be over**
  - ♦ if you decide to accept the decision that turns down your appeal, the appeals process is over
  - ♦ if you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal

Level 5 appeal

A judge at the **Federal District Court** will review your appeal

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court

How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns

What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems about quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process:

- **Quality of your medical care**
  - ♦ are you unhappy with the quality of care you got (including care in the hospital)?
- **Respecting your privacy**
  - ♦ did someone not respect your right to privacy or share confidential information?
- **Disrespect, poor customer service, or other negative behaviors**
  - ♦ has someone been rude or disrespectful to you?
  - ♦ are you unhappy with our Member Services?
  - ♦ do you feel you're being encouraged to leave our plan?
- **Waiting times**
  - ♦ are you having trouble getting an appointment, or waiting too long to get it?
  - ♦ have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by Member Services or other staff at our plan?
    - – Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription
- **Cleanliness**
  - ♦ are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
- **Information you get from our plan**
  - ♦ did we fail to give you a required notice?
  - ♦ is our written information hard to understand?
- **Timeliness (these types of complaints are all about the timeliness of our actions related to coverage decisions and appeals).** If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples:
  - ♦ you asked us for a fast coverage decision or a fast appeal, and we said no; you can make a complaint
  - ♦ you believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint
  - ♦ you believe we aren't meeting deadlines for covering or reimbursing you for certain medical services or drugs that were approved; you can make a complaint
  - ♦ you believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint

How to make a complaint

- A **complaint** is also called a **grievance**
- **Making a complaint** is called **filing a grievance**
- **Using the process for complaints** is called **using the process for filing a grievance**
- A **fast complaint** is called an **expedited grievance**

Step 1: Contact us promptly – either by phone or in writing

- **Calling Member Services is usually the first step**. If there's anything else you need to do, Member Services will let you know
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us**. If you put your complaint in writing, we'll respond to your complaint in writing
- **If you have a complaint, we'll try to resolve your complaint over the phone**. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. Your grievance must explain your concern, such as why you're dissatisfied with the services you received. Go to the "Phone Numbers and Resources" section for whom you should contact if you have a complaint
  - ♦ you must submit your grievance to us (orally or in writing) within 60 calendar days of the event or incident. We must address your grievance as quickly as your health requires, but no later than 30 calendar days after receiving your complaint. We may extend the time frame to make our decision by up to 14 calendar days if you ask for an extension, or if we justify a need for additional information and the delay is in your best interest
  - ♦ you can file a fast grievance about our decision not to expedite a coverage decision or appeal for medical care or items, or if we extend the time we need to make a decision about a coverage decision or appeal for medical care or items. We must respond to your fast grievance **within 24 hours**
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about

Step 2: We look into your complaint and give you our answer

- **If possible, we'll answer you right away**. If you call us with a complaint, we may be able to give you an answer on the same phone call
- **Most complaints are answered within 30 calendar days**. If we need more information and the delay is in your best interest or if you ask for more time, **we can take up to 14 more calendar days** (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing

- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you

You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization**. The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. The "Phone Numbers and Resources" section has contact information
- **Or you can make your complaint to both the Quality Improvement Organization and us at the same time**

You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to **www.medicare.gov/my/Medicare-complaint**. You can also call **1-800-MEDICARE (1-800-633-4227)**. TTY/TDD users call **1-877-486-2048**.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (1-866-444-3272)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Binding Arbitration

For all claims subject to this "Binding Arbitration" section, both Claimants and Respondents give up the right to a jury or court trial and accept the use of binding arbitration. Insofar as this "Binding Arbitration" section applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this *EOC*. Such retroactive application shall be binding only on the Kaiser Permanente Parties.

Scope of arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *EOC* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. ("Health Plan"), including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of the legal theories upon which the claim is asserted
- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- Governing law does not prevent the use of binding arbitration to resolve the claim

Members enrolled under this *EOC* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeal procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

As referred to in this "Binding Arbitration" section, "Member Parties" include:

- A Member
- A Member's heir, relative, or personal representative
- Any person claiming that a duty to them arises from a Member's relationship to one or more Kaiser Permanente Parties

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any Southern California Permanente Medical Group or The Permanente Medical Group physician
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties
- Any employee or agent of any of the foregoing

"Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts a claim as described above. "Respondent" refers to a Member Party or a Kaiser Permanente Party against whom a claim is asserted.

Rules of Procedure

Arbitrations shall be conducted according to the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of Procedure") developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from Member Services.

Initiating arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and phone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include in the Demand for Arbitration all claims against Respondents that are based on the same incident, transaction, or related circumstances.

Serving Demand for Arbitration

Health Plan, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

Kaiser Foundation Health Plan, Inc.
Legal Department, Professional & Public Liability
393 E. Walnut St.
Pasadena, CA 91188

Service on that Respondent shall be deemed completed when received. All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing fee

The Claimants shall pay a single, nonrefundable filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or Respondents named in the Demand for Arbitration.

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling Member Services.

Number of arbitrators

The number of arbitrators may affect the Claimants' responsibility for paying the neutral arbitrator's fees and expenses (see the Rules of Procedure).

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing after a dispute has arisen and a request for binding arbitration has been submitted that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of arbitrators' fees and expenses

Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the Rules of Procedure. In all other arbitrations, the fees and

expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs

Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this "Binding Arbitration" section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

General provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondent served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for non-economic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration" section. In accord with the rule that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration" section shall not be denied, stayed, or otherwise impeded because a dispute between a Member Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with another party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2027, your last minute of coverage was at 11:59 p.m. on December 31, 2026). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *EOC* after your membership terminates, except:

- As provided under "Payments after Termination" in this "Termination of Membership" section
- If you are receiving covered Services as an acute care hospital inpatient on the termination date, we will continue to cover those hospital Services (but not physician Services or any other Services) until you are discharged

Until your membership terminates, you remain a Senior Advantage Member and must continue to receive your medical care from us, except as described in the "Emergency Services and Urgent Care" section about Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care and the "Benefits and Your Cost Share" section about out-of-area dialysis care.

Note: If you enroll in another Medicare Health Plan or a prescription drug plan, your Senior Advantage membership will terminate as described under "Disenrolling from Senior Advantage" in this "Termination of Membership" section. Such a termination will not affect your enrollment in your Group's non-Medicare plan.

Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Premiums,

Eligibility, and Enrollment" section your Group will notify you of the date that your membership will end. Your membership termination date is the first day you are not covered. For example, if your termination date is January 1, 2027, your last minute of coverage was at 11:59 p.m. on December 31, 2026.

Also, we will terminate your Senior Advantage membership under this *EOC* on the last day of the month if you:

- Are temporarily absent from our Service Area for more than six months in a row
- Permanently move from our Service Area
- No longer have Medicare Part B
- Medicare becomes primary, for example, when you retire
- Enroll in another Medicare Health Plan (for example, a Medicare Advantage Plan or a Medicare prescription drug plan). The Centers for Medicare & Medicaid Services will automatically terminate your Senior Advantage membership when your enrollment in the other plan becomes effective
- Are not a U.S. citizen or lawfully present in the United States. The Centers for Medicare & Medicaid Services will notify us if you are not eligible to remain a Member on this basis. We must disenroll you if you do not meet this requirement

In addition, if you're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our Senior Advantage Plan and you'll lose drug coverage.

Note: If you lose eligibility for Senior Advantage due to any of these circumstances, you will be able to continue membership under your Group's non-Medicare plan, or if you retire, you may be able to enroll in a different Senior Advantage plan either through your Group (if available) or as discussed under "Conversion to an Individual Plan" below. Contact your Group for information.

Termination of *Agreement*

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. Your Group is required to notify Subscribers in writing if its *Agreement* with us terminates.

Disenrolling from Senior Advantage

You may terminate (disenroll from) your Senior Advantage membership and remain a Member through your Group's non-Medicare plan at any time. Your disenrollment effective date will be the first day of the month following our receipt of your disenrollment request.

You may request disenrollment by:

- Calling toll free **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**
- Sending written notice to the following address:
  Kaiser Permanente
  Medicare Unit
  P.O. Box 232400
  San Diego, CA 92193-2400

Other Medicare Health Plans. If you want to enroll in another Medicare Health Plan or a Medicare prescription drug plan, you should first confirm with the other plan and your Group that you're able to enroll. Your new plan or your Group will tell you the date when your membership in the new plan begins and your Senior Advantage membership will end on that same day (your disenrollment date).

The Centers for Medicare & Medicaid Services will let us know if you enroll in another Medicare Health Plan, so you won't need to send us a disenrollment request.

Original Medicare. If you request disenrollment from Senior Advantage and you don't enroll in another Medicare Health Plan, you will automatically be enrolled in Original Medicare when your Senior Advantage membership terminates (your disenrollment date). On your disenrollment date, you can start using your red, white, and blue Medicare card to get services under Original Medicare. You won't get anything in writing that tells you that you have Original Medicare after you disenroll. If you choose Original Medicare and you want to continue to get Medicare Part D prescription drug coverage, you will need to enroll in a prescription drug plan.

If you receive Extra Help from Medicare to pay for your prescription drugs, and you switch to Original Medicare and don't enroll in a separate Medicare Part D prescription drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Note: If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may need to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Termination of Contract with the Centers for Medicare & Medicaid Services

If our contract with the Centers for Medicare & Medicaid Services to offer Senior Advantage terminates, your Senior Advantage membership will terminate on the same date. We'll send you advance written notice and advise you of your health care options. However, you will still be enrolled under your Group's non-Medicare plan.

Termination for Cause

We may terminate your membership by sending you advance written notice if you commit one of the following acts:

- If you continuously behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for our other members. We cannot make you leave our Senior Advantage Plan for this reason unless we get permission from Medicare first
- If you let someone else use your plan membership card to get medical care. We cannot make you leave our Senior Advantage Plan for this reason unless we get permission from Medicare first. If you are disenrolled for this reason, the Centers for Medicare & Medicaid Services may refer your case to the Inspector General for additional investigation
- You commit theft from Health Plan, from a Plan Provider, or at a Plan Facility
- You intentionally misrepresent membership status or commit fraud in connection with your obtaining membership. We cannot make you leave our Senior Advantage Plan for this reason unless we get permission from Medicare first
- If you become incarcerated (go to prison)
- You knowingly falsify or withhold information about other parties that provide reimbursement for your prescription drug coverage

If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future until you have completed a Member Orientation and have signed a statement promising future compliance. We may report fraud and other illegal acts to the authorities for prosecution.

Termination for Nonpayment of Premiums

If we do not receive Premiums for your Family, we may terminate the memberships of everyone in your Family.

Termination of a Product or all Products

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we'll terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's *Agreement* by sending you written notice at least 180 days before the *Agreement* terminates.

Payments after Termination

If we terminate your membership for cause or for nonpayment, we will:

- Refund any amounts we owe for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Requests for Payment" section. We will deduct any amounts you owe Health Plan or Plan Providers from any payment we make to you

Review of Membership Termination

If you believe that we terminated your Senior Advantage membership because of your ill health or your need for care, you may file a complaint as described in the "Coverage Decisions, Appeals, and Complaints" section.

Continuation of Membership

If your membership under your Group's non-Medicare plan ends, you may be eligible to maintain Health Plan membership without a break in coverage (group coverage) or you may be eligible to convert to an individual (nongroup) plan.

Continuation of Group Coverage

COBRA

You may be able to continue your coverage under this Senior Advantage *EOC* for a limited time after you would otherwise lose eligibility, if required by the

federal Consolidated Omnibus Budget Reconciliation Act ("COBRA"). COBRA applies to most employees (and most of their covered family Dependents) of most employers with 20 or more employees.

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll, you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Group for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and Premiums may change, and where to send your Premium payments.

As described in "Conversion from Group Membership to an Individual Plan" in this "Continuation of Membership" section, you may be able to convert to an individual (nongroup) plan if you don't apply for COBRA coverage, or if you enroll in COBRA and your COBRA coverage ends.

Coverage for a disabling condition

If you became Totally Disabled while you were a Member under your Group's *Agreement* with us and while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates and is not renewed, we will cover Services for your totally disabling condition until the earliest of the following events occurs:

- 12 months have elapsed since your Group's *Agreement* with us terminated
- You are no longer Totally Disabled
- Your Group's *Agreement* with us is replaced by another group health plan without limitation as to the disabling condition

Your coverage will be subject to the terms of this *EOC*, including Cost Share, but we will not cover Services for any condition other than your totally disabling condition.

For Subscribers and adult Dependents, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months, and makes the person unable to engage in any employment or occupation, even with training, education, and experience.

For Dependent children, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the illness or injury makes the child unable to substantially engage in any of the normal activities of children in good health of like age.

To request continuation of coverage for your disabling condition, you must call Member Services within 30 days after your Group's *Agreement* with us terminates.

Conversion from Group Membership to an Individual Plan

After your Group notifies us to terminate your Group membership, we will send a termination letter to the Subscriber's address of record. The letter will include information about options that may be available to you to remain a Health Plan Member.

Kaiser Permanente Conversion Plan

If you want to remain a Health Plan Member, one option that may be available is our Senior Advantage Individual Plan. You may be eligible to enroll in our individual plan if you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section. Individual plan coverage begins when your Group coverage ends. The premiums and coverage under our individual plan are different from those under this *EOC* and will include Medicare Part D prescription drug coverage.

However, if you are no longer eligible for Senior Advantage and Group coverage, you may be eligible to convert to our non-Medicare individual plan, called "Kaiser Permanente Individual–Conversion Plan." You may be eligible to enroll in our Individual–Conversion Plan if we receive your enrollment application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

You may not be eligible to convert if your membership ends for the reasons stated under "Termination for Cause" or "Termination of *Agreement"* in the "Termination of Membership" section.

Miscellaneous Provisions

Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of your Group's *Agreement*, including this *EOC*.

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *EOC*, your Group is required to inform you in accord with applicable law and your Group's *Agreement*.

Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *EOC*.

Assignment

You may not assign this *EOC* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

Attorney and Advocate Fees and Expenses

In any dispute between a Member and Health Plan, the Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses.

Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this *EOC* and we have the discretionary authority to review and evaluate claims that arise under this *EOC*. We conduct this evaluation independently by interpreting the provisions of this *EOC*. We may use medical experts to help us review claims. If coverage under this *EOC* is subject to the Employee Retirement Income Security Act ("ERISA") claims procedure regulation (29 CFR 2560.503-1), then we are a "named claims fiduciary" to review claims under this *EOC*.

EOC Binding on Members

By electing coverage or accepting benefits under this *EOC*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *EOC*.

ERISA Notices

This "ERISA Notices" section applies only if your Group's health benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"). We provide these notices to assist ERISA-covered groups in complying with ERISA. Coverage for Services described in these notices is subject to all provisions of this *EOC*.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the birthing person or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the birthing person's or newborn's attending provider, after consulting with the birthing person, from discharging the birthing person or their newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same Cost Share applicable to other medical and surgical benefits provided under this plan.

Governing Law

Except as preempted by federal law, this *EOC* will be governed in accord with California law and any provision that is required to be in this *EOC* by state or federal law shall bind Members and Health Plan whether or not set forth in this *EOC*.

Group and Members Not Our Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

No Waiver

Our failure to enforce any provision of this *EOC* will not constitute a waiver of that or any other provision, or

impair our right thereafter to require your strict performance of any provision.

Notices Regarding Your Coverage

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call Member Services and Social Security toll free at **1-800-772-1213** (TTY users call **1-800-325-0778**) as soon as possible to give us their new address. If a Member does not reside with the Subscriber, or needs to have confidential information sent to an address other than the Subscriber's address, they should call Member Services to discuss alternate delivery options.

Note: When we tell your Group about changes to this *EOC* or provide your Group other information that affects you, your Group is required to notify the Subscriber within 30 days after receiving the information from us. The Subscriber is also responsible for notifying Group of any change in contact information.

Notice about Medicare Secondary Payer Subrogation Rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Kaiser Permanente Senior Advantage, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment or from any person or organization obligated to pay for the Services.

Public Policy Participation

The Kaiser Foundation Health Plan, Inc., Board of Directors establishes public policy for Health Plan. A list of the Board of Directors is available on our website at **kp.org** or from Member Services. If you would like to provide input about Health Plan public policy for consideration by the Board, please send written comments to:

Kaiser Foundation Health Plan, Inc.
Office of Board and Corporate Governance Services
One Kaiser Plaza, 19th Floor
Oakland, CA 94612

Telephone Access (TTY)

If you use a text telephone device (TTY, also known as TDD) to communicate by phone, you can use the California Relay Service by calling 711.

Phone Numbers and Resources

Kaiser Permanente Senior Advantage contacts

For help with claims, billing, or member card questions, call or write to our plan's Member Services. We'll be happy to help you.

Member Services – Contact Information

Call **1-800-443-0815**

Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.

Member Services also has free language interpreter services available for non-English speakers.

TTY **711**

Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.

Write Your local Member Services office (see the Provider Directory for locations).

Website **kp.org**

How to ask for a coverage decision or appeal, or make a complaint about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision.

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes.

For more information on how to ask for coverage decisions or appeals, or make a complaint about your medical care, go to the "Coverage Decisions, Appeals, and Complaints" section.

Coverage Decisions, Appeals, or Complaints for Medical Care – Contact Information

Call **1-800-443-0815**

Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.

If your coverage decision, appeal, or complaint qualifies for a fast decision as described in the "Coverage Decisions, Appeals, and Complaints" section, call the Expedited Review Unit at **1-888-987-7247**, 8:30 a.m. to 5 p.m., seven days a week.

TTY **711**

Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.

Fax If your coverage decision, appeal, or complaint qualifies for a fast decision, fax your request to our Expedited Review Unit at **1-888-987-2252**.

Write For a standard coverage decision or complaint, write to your local Member Services office (see the Provider Directory for locations).

For a standard appeal, write to the address shown on the denial notice we send you.

If your coverage decision, appeal, or complaint qualifies for a fast decision, write to:

Kaiser Permanente
Expedited Review Unit
P.O. Box 1809
Pleasanton, CA 94566

Website. You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to **https://www.Medicare.gov/MedicareComplaintForm/home.aspx**.

How to ask for a coverage decision about your Part D drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your Part D drugs. For more information on how to ask for coverage decisions about your Part D drugs, go to the "Coverage Decisions, Appeals, and Complaints" section.

Coverage Decisions for Part D drugs – Contact Information

Call **1-888-791-7213**

Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.

TTY **711**

Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.

Fax **1-844-403-1028**

Write OptumRx
c/o Prior Authorization
P.O. Box 2975
Mission, KS 66201

Website **kp.org**

How to ask for an appeal about your Part D drugs

An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for appeals about your Part D drugs, go to the "Coverage Decisions, Appeals, and Complaints" section.

Appeals for Part D drugs – Contact Information

Call **1-866-206-2973**

Calls to this number are free. Seven days a week, 8:30 a.m. to 5 p.m.

TTY **711**

Calls to this number are free. Seven days a week, 8:30 a.m. to 5 p.m.

Fax **1-866-206-2974**

Write Kaiser Permanente
Medicare Part D Unit
P.O. Box 1809
Pleasanton, CA 94566

Website **kp.org**

How to make a complaint about your Part D drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your Part D drugs, go to the "Coverage Decisions, Appeals, and Complaints" section.

Complaints about Part D drugs – Contact Information

Call **1-800-443-0815**

Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.

If your complaint qualifies for a fast decision, call the Part D Unit at **1-866-206-2973**, 8:30 a.m. to 5 p.m., seven days a week. Go to the "Coverage Decisions, Appeals, and Complaints" section to find out if your issue qualifies for a fast decision.

TTY **711**

Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.

Fax If your complaint qualifies for a fast review, fax your request to our Part D Unit at **1-866-206-2974**.

Write For a standard complaint, write to your local Member Services office (see the Provider Directory for locations).

If your complaint qualifies for a fast decision, write to:

Kaiser Permanente
Medicare Part D Unit
P.O. Box 1809
Pleasanton, CA 94566

Medicare Website To submit a complaint about our plan directly to Medicare, go to **https://www.Medicare.gov/MedicareComplaintForm/home.aspx**.

How to ask us to pay our share of the cost for medical care or a drug you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to the "Requests for Payment" section for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to the "Coverage Decisions, Appeals, and Complaints" section for more information.

Payment Requests – Contact Information

Call **1-800-443-0815**

Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.

Note: If you're requesting payment of a Part D drug that was prescribed by a Plan Provider and obtained from a Plan Pharmacy, call our Part D unit at **1-866-206-2973**, 8:30 a.m. to 5 p.m., seven days a week.

TTY **711**

Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.

Write **For medical care:**

Kaiser Permanente
Claims Department
P.O. Box 7004
Downey, CA 90242-7004

For Part D drugs:

If you're requesting payment of a Part D drug that was prescribed and provided by a Plan Provider, you can fax your request to **1-866-206-2974** or mail it to:

Kaiser Permanente
Medicare Part D Unit
P.O. Box 1809
Pleasanton, CA 94566

Website **kp.org**

Get help from Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations, including our plan.

Medicare – Contact Information

Call **1-800-MEDICARE (1-800-633-4227)**

Calls to this number are free. 24 hours a day, 7 days a week.

TTY **1-877-486-2048**

This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.

Chat Live Chat Live at **www.Medicare.gov/talk-to-someone**.

Write Medicare
P.O. Box 1270
Lawrence, KS 66044

Website **https://www.Medicare.gov**

- Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide
- Find Medicare-participating doctors or other health care providers and suppliers
- Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits)
- Get Medicare appeals information and forms
- Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals
- Look up helpful websites and phone numbers

You can also visit **https://www.Medicare.gov** to tell Medicare about any complaints you have about our plan.

To submit a complaint to Medicare, go to **https://www.Medicare.gov/my/medicare-complaint**. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In California, the SHIP is called the Health Insurance Counseling and Advocacy Program (HICAP).

HICAP is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

HICAP counselors can help you understand your Medicare rights, help you make complaints about your Services or treatment, and straighten out problems with your Medicare bills. HICAP counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices, and answer questions about switching plans.

Health Insurance Counseling and Advocacy Program (California's SHIP) – Contact Information

Call **1-800-434-0222**

TTY **711**

Write Your HICAP office for your county.

Website **www.aging.ca.gov/HICAP/**

Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For California, the Quality Improvement Organization is called Commence Health. Commence Health has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. Commence Health is an independent organization. It's not connected with our plan.

Contact Commence Health in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis
- You think coverage for your hospital stay is ending too soon
- You think coverage for your home health care, Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon

Commence Health (California's Quality Improvement Organization) – Contact Information

Call **1-877-588-1123**

Calls to this number are free. Monday through Friday, 9 a.m. to 5 p.m. Weekends and holidays, 10 a.m. to 4 p.m.

TTY **711**

Write Commence Health
BFCC– QIO Program

P.O. Box 2687
Virigina Beach, VA 23450

Website https://www.livantaqio.cms.gov/en

Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment. Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, contact Social Security to let them know.

Social Security – Contact Information

Call **1-800-772-1213**

Calls to this number are free. Available 8 a.m. to 7 p.m., Monday through Friday.

Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.

TTY **1-800-325-0778**

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 a.m. to 7 p.m., Monday through Friday.

Website www.SSA.gov

Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other Cost Share. Some people with QMB are also eligible for full Medicaid benefits (QMB+)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. Some people with SLMB are also eligible for full Medicaid benefits (SLMB+)
- **Qualifying Individual (QI):** Helps pay Part B premiums
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums

To find out more about Medicaid and Medicare Savings Programs, contact Medi-Cal.

Medi-Cal (California's Medicaid program) – Contact Information

Call **1-800-430-4263**

Calls to this number are free. Monday through Friday, 8 a.m. to 6 p.m.

TTY **1-800-430-7077**

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Write CA Department of Health Care Services
Health Care Options
P.O. Box 989009
West Sacramento, CA 95798-9850

Website www.healthcareoptions.dhcs.ca.gov/

Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information

Call **1-877-772-5772**

Calls to this number are free.

Press "0," to speak with an RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9 a.m. to 12 p.m. on Wednesday.

Press "1," to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.

TTY **1-312-751-4701**

This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren't free.

Website **https://RRB.gov/**

Group Insurance or Other Health Insurance from an Employer

If you have any questions about your employer-sponsored Group plan, please contact your Group's benefits administrator. You can ask about your employer or retiree health benefits, any contributions toward the Group's premium, eligibility, and enrollment periods.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact that group's benefits administrator. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

Important Notices

Notice of Language Assistance

English: ATTENTION. Language assistance is available at no cost to you. You can ask for interpreter services, including sign language interpreters. You can ask for materials translated into your language or alternative formats, such as braille, audio, or large print. You can also request auxiliary aids and devices at our facilities. Call our Member Services department for help. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week
- All others: **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week

Arabic: تنبيه. المساعدة اللغوية متوفرة بدون تكلفة عليك. يمكنك طلب خدمات الترجمة، بما في ذلك مترجمي لغة الإشارة. يمكنك طلب وثائق مترجمة بلغتك أو بصيغ بديلة مثل طريقة برايل للمكفوفين أو ملف صوتي أو الطباعة بأحرف كبيرة. يمكنك أيضًا طلب وسائل مساعدة وأجهزة مساعدة في مرافقنا. اتصل مع قسم خدمات الأعضاء لدينا للحصول على المساعدة. لا تعمل خدمات الأعضاء في العطلات الرئيسية.

- Medicare، بما في ذلك D-SNP على: **1-800-443-0815** (TTY **711**)، 8 صباحاً إلى 8 مساءً، 7 أيام في الأسبوع
- Medi-Cal: على **1-855-839-7613** (TTY **711**)، 24 ساعة في اليوم، 7 أيام في الأسبوع
- الآخرين جميعاً: **1-800-464-4000** (TTY **711**)، 24 ساعة في اليوم، 7 أيام في الأسبوع

Amenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Լեզվական աջակցությունը հասանելի է ձեզ անվճար: Դուք կարող եք խնդրել բանավոր թարգմանության ծառայություններ, այդ թվում՝ ժեստերի լեզվի թարգմանիչներ: Դուք կարող եք խնդրել ձեր լեզվով թարգմանված նյութեր կամ այլընտրանքային ձևաչափեր, ինչպիսիք են՝ բրայլը, ձայնագրությունը կամ խոշոր տառատեսակը: Դուք կարող եք նաև դիմել օժանդակ աջակցության և սարքերի համար, որոնք առկա են մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների սպասարկման բաժին: Անդամների սպասարկման բաժինը փակ է հիմնական տոն օրերին:

- Medicare, ներառյալ D-SNP՝ **1-800-443-0815** (TTY **711**), 8 a.m.-ից 8 p.m.-ը, շաբաթը 7 օր
- Medi-Cal՝ **1-855-839-7613** (TTY **711**), օրը 24 ժամ, շաբաթը 7 օր
- Մյուս բոլորը՝ **1-800-464-4000** (TTY **711**), օրը 24 ժամ, շաբաթը 7 օր

Chinese：请注意，我们有免费语言协助。您可以要求我们提供口译服务，包括手语翻译员。您可以要求将资料翻译成您所使用的语言或其他格式的版本，如盲文、音频或大字版。您还可以要求使用我们设施中的语言辅助工具和设备。请联系会员服务部以获取帮助。重要节假日期间会员服务不开放。

- Medicare，包括 D-SNP：**1-800-443-0815** (TTY **711**)，每周 7 天，上午 8 点至晚上 8 点
- Medi-Cal：**1-855-839-7613** (TTY 711)，每周 7 天，每天 24 小时
- 所有其他保险计划：**1-800-757-7585** (TTY **711**)，每周 7 天，每天 24 小时

Farsi: توجه. امکان بهره‌مندی از مساعدت زبانی به طور رایگان برای شما وجود دارد. می‌توانید خدمات ترجمه شفاهی را درخواست کنید، از جمله مترجمان زبان اشاره. همچنین می‌توانید مطالب ترجمه‌شده به زبان خودتان یا در قالب‌های جایگزین را درخواست کنید، از جمله خط بریل، فایل صوتی، یا چاپ با حروف درشت. همچنین می‌توانید امکانات و دستگاه‌های کمکی را از مراکز ما درخواست کنید. برای دریافت کمک، با خدمات اعضای ما تماس بگیرید. خدمات اعضاء، در تعطیلات رسمی بسته است.

- Medicare، شامل D-SNP: با شماره **1-800-443-0815** (TTY **711**) از 8 صبح تا 8 عصر، در 7 روز هفته تماس بگیرید
- Medi-Cal: با شماره **1-855-839-7613** (TTY **711**)، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید
- همه موارد دیگر: با شماره **1-800-464-4000** (TTY **711**)، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید

Hindi: ध्यान दें। भाषा सहायता आपके लिए बिना किसी शुल्क के उपलब्ध है। आप दुभाषिया सेवाओं के लिए अनुरोध कर सकते हैं, जिसमें साइन लैंगुवेज के दुभाषिये भी शामिल हैं। आप सामग्रियों को अपनी भाषा या वैकल्पिक प्रारूप, जैसे कि ब्रेल, ऑडियो, या बड़े प्रिंट में अनुवाद करवाने के लिए भी कह सकते हैं। आप हमारे सुविधा-केंद्रों पर सहायक साधनों और उपकरणों का भी अनुरोध कर सकते हैं। सहायता के लिए हमारे सदस्य सेवा विभाग को कॉल करें। सदस्य सेवा विभाग मुख्य छुट्टियों वाले दिन बंद रहता है।

- Medicare, जिसमें D-SNP शामिल है: **1-800-443-0815** (TTY **711**), सुबह 8 बजे से रात 8 बजे तक, सप्ताह के 7 दिन
- Medi-Cal: **1-855-839-7613** (TTY **711**), दिन के चौबीस घंटे, सप्ताह के 7 दिन
- बाकी सभी: **1-800-464-4000** (TTY **711**), दिन के चौबीस घंटे, सप्ताह के 7 दिन

Hmong: FAJ SEEB. Muaj kev pab txhais lus pub dawb rau koj. Koj muaj peev xwm thov kom pab txhais lus, suav nrog kws txhais lus piav tes. Koj muaj peev xwm thov kom muab cov ntaub ntawv no txhais ua koj yam lus los sis ua lwm hom, xws li hom ntawv rau neeg dig muag xuas, tso ua suab lus, los sis luam tawm kom koj. Koj kuj tuaj yeem thov kom muab tej khoom pab dawb thiab tej khoom siv txhawb tau rau ntawm peb cov chaw kuaj mob. Hu mus thov kev pab

rau ntawm peb Lub Chaw Pab Tswv Cuab. Lub chaw pab tswv cuab kaw rau cov hnub so uas tseem ceeb.

- Medicare, suav nrog D-SNP: **1-800-443-0815** (TTY **711**), 8 teev sawv ntxov txog 8 teev tsaus ntuj, 7 hnub hauv ib lub vij
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 teev hauv ib hnub, 7 hnub hauv ib lub vij
- Tag nrho lwm yam: **1-800-464-4000** (TTY **711**), 24 teev hauv ib hnub, 7 hnub hauv ib lub vij

Japanese: ご注意。言語サポートは無料でご利用いただけます。あなたは手話通訳を含む通訳サービスを依頼できます。点字、大型活字、または録音音声など、あなたの言語に翻訳された資料や別のフォーマットの資料を求めることができます。当社の施設では補助器具や機器の要請も承っております。支援が必要な方は、加入者サービス部門にお電話ください。加入者向けサービスは主要な休日では営業しておりません。

- D-SNP を含む Medicare：**1-800-443-0815**（TTY **711**）、午前 8 時から午後 8 時まで、年中無休
- Medi-Cal：**1-855-839-7613**（TTY **711**）、24 時間、年中無休
- その他全て：**1-800-464-4000**（TTY **711**）、24 時間、年中無休

Khmer (Cambodian): យកចិត្តទុកដាក់។ ជំនួយភាសាគឺមានដោយមិនគិតថ្លៃសម្រាប់អ្នក។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ រួមទាំងអ្នកបកប្រែភាសាសញ្ញាផងដែរ។ អ្នកអាចស្នើសុំឯកសារដែលត្រូវបានបកប្រែជាភាសារបស់អ្នក ឬទម្រង់ផ្សេងទៀតដូចជាអក្សរស្ដាប សំឡេង ឬអក្សរធំៗ។ អ្នកក៏អាចស្នើសុំជំនួយបន្ថែម និងឧបករណ៍ជំនួយនៅតាមកន្លែងរបស់យើងផងដែរ។ សូមទូរសព្ទទៅផ្នែកសេវាសមាជិករបស់យើងសម្រាប់ជំនួយ។ សេវាសមាជិកត្រូវបានបិទនៅថ្ងៃឈប់សម្រាកសំខាន់ៗ។

- Medicare, រួមទាំង D-SNP: **1-800-443-0815** (TTY **711**) ពីម៉ោង 8 ព្រឹក ដល់ 8 យប់ 7 ថ្ងៃក្នុងមួយសប្ដាហ៍
- Medi-Cal: **1-855-839-7613** (TTY **711**) 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្ដាហ៍
- ផ្សេងៗទៀត៖ **1-800-464-4000** (TTY **711**) 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្ដាហ៍

Korean: 안내 사항. 무료 언어 지원 제공. 수화 통역사를 포함한 통역 서비스를 요청할 수 있습니다. 한국어로 번역된 자료 또는 점자, 오디오 또는 큰 글씨와 같은 대체 형식의 자료를 요청할 수 있습니다. 저희 시설에서 보조 기구와 장치를 요청할 수도 있습니다. 가입자 서비스 부서에 도움을 요청하시기 바랍니다. 주요 공휴일에는 가입자 서비스를 운영하지 않습니다.

- Medicare(D-SNP 포함), 주 7 일 오전 8 시~오후 8 시에 **1-800-443-0815** (TTY **711**) 번으로 문의
- Medi-Cal: **1-855-839-7613** (TTY **711**), 주 7 일, 하루 24 시간
- 기타: **1-800-464-4000** (TTY **711**), 주 7 일, 하루 24 시간

Laotian: ໂປດຊາບ. ມີການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ທ່ານສ າມາດຂໍບໍລິການນາຍພາສາ, ລວມທັງນາຍພາສາມື. ທ່ານ ສາມາດຂໍໃຫ້ແປເອກະສານນີ້ເປັນພາສາຂອງທ່ານ ຫຼື ຮູບ ແບບອື່ນ ເຊັ່ນ ອັກສອນນູນ, ສຽງ, ຫຼື ການພິມຂະໜາດໃ ຫຍ່. ນອກຈາກນັ້ນທ່ານຍັງສາມາດຮ້ອງຂໍເຄື່ອງຊ່ວຍຟັງ ແລະ ອຸປະກອນການຊ່ວຍເຫຼືອໃນສະຖານທີ່ຂອງພວກ ເຮົາ. ໂທຫາພະແນກບໍລິການສະມາຊິກຂອງພວກເຮົາເ ພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. ພະແນກບໍລິການສະມາຊິກແ ມ່ນປິດໃນວັນພັກທີ່ສໍາຄັນຕ່າງໆ.

- Medicare, ລວມທັງ D-SNP: **1-800-443-0815** (TTY **711**), 8 ໂມງເຊົ້າ ຫາ 8 ໂມງແລງ, 7 ວັນຕໍ່ອາທິດ
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ
- ອື່ນໆ: **1-800-464-4000** (TTY **711**), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ

Mien: CAU FIM JANGX LONGX OC. Ninh mbuo duqv liepc ziangx tengx faan waac bun meih muangx mv zuqc heuc meih ndorqv nyaanh cingv oc. Meih corc haiv tov taux ninh mbuo tengx lorz faan waac bun meih, caux longc buoz wuv faan waac bun muangx. Meih aengx haih tov taux ninh mbuo dorh nyungc horngh jaa dorngx faan benx meih nyei waac a'fai fiev bieqc da'nyeic diuc daan, fiev benx domh nzangc-pokc bun hluo, bungx waac-qiez bun uangx, a'fai aamx bieqc domh zeiv-linh. Meih corc haih tov longc benx wuotc ginc jaa-dorngx tengx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Mborqv finx lorz taux yie mbuo dinc zangc domh gorn ziux goux baengc mienh nyei dorngx liouh tov heuc ninh mbuo tengx nzie weih. Ziux goux baengc mienh nyei gorn zangc se gec mv zoux gong yiem gingc nyei hnoi-nyieqc oc.

- Medicare, caux D-SNP: **1-800-443-0815** (TTY **711**), yiem 8 dimv lungh ndorm taux 8 dimv lungh muonx, yietc norm leiz baaix zoux gong 7 hnoi
- Medi-Cal: **1-855-839-7613** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi
- Yietc zungv da'nyeic diuc jauv-louc: **1-800-464-4000** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi

Navajo: GIHA. Tséé' naalkáah sidá'ígíí éí doo tł'éé' íił'į' dah sidáa'ígíí. Tł'éé'góó tł'ízí'ígíí éí tséé' naalkáah sidá'ígíí bikáa' dah sidaaígíí, t'á'ii bik'eh dah na'ałkaígíí. T'á'ii éí tł'éé'góó tł'ízí'ígíí bik'eh dah deidiyós, t'á'ii éí bi'éé' bik'eh dah na'ałkaígíí bik'eh dah deidiyós. T'á'ii bik'eh dah na'ałkaígíí bikáa' dah na'ałkaígíí t'áá ałtso bik'eh dah deidiyós. Bi'éé' naalkáah sidá'ígíí bik'eh ha'a'aah. T'á'ii bik'eh dah na'ałkaígíí éí bik'eh dah naazhjaa'ígíí bik'eh dah na'ałkaígíí.

- Medicare, bikáa' dah deidiyós D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. góó 8 p.m., 7 jį t'ááłá'í damóo
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 tł'ohch'oolí t'ááłá'í jį, 7 jį t'ááłá'í damóo
- T'áá ał'ąą: **1-800-464-4000** (TTY **711**), 24 tł'ohch'oolí t'ááłá'í jį, 7 jį t'ááłá'í damóo

Punjabi: ਧਿਆਨ ਦਿਓ। ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ਿਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਿੱਤੇ ਜਾਣ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ, ਜਿਸ ਵਿੱਚ ਸਾਈਨ ਲੈਂਗੁਵੇਜ਼ ਦੇ ਦੁਭਾਸ਼ਿਏ ਵੀ ਸ਼ਾਮਲ ਹਨ। ਤੁਸੀਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ, ਜਾਂ ਕਿਸੇ ਵੈਕਲਪਿਕ ਫਾਰਮੈਟ ਵਿੱਚ ਅਨੁਵਾਦਿਤ ਕਰਨ ਲਈ ਵੀ ਕਹਿ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸਹੂਲਤਾਂ 'ਤੇ ਸਹਾਇਕ ਏਡਜ਼ ਅਤੇ ਉਪਕਰਨਾਂ ਲਈ ਵੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ ਸਾਡੇ ਮੈਂਬਰਾਂ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦੇ ਵਿਭਾਗ ਨੂੰ ਕਾੱਲ ਕਰੋ। ਮੈਂਬਰਾਂ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਾ ਵਿਭਾਗ ਮੁੱਖ ਛੁਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ।

- Medicare, ਜਿਸ ਵਿੱਚ D-SNP ਵੀ ਸ਼ਾਮਲ ਹੈ: **1-800-443-0815** (TTY **711**), ਸਵੇਰੇ 8 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 8 ਵਜੇ ਤੱਕ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- Medi-Cal: **1-855-839-7613** (TTY **711**), ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- ਬਾਕੀ ਸਾਰੇ: **1-800-464-4000** (TTY **711**), ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ

Russian: ВНИМАНИЕ! Для Вас доступны бесплатные услуги перевода. Вы можете запросить услуги устного перевода, в том числе услуги переводчика языка жестов. Вы также можете запросить материалы, переведенные на ваш язык или в альтернативных форматах, например шрифтом Брайля, крупным шрифтом или в аудиоформате. Вы также можете запросить дополнительные приспособления и вспомогательные устройства в наших учреждениях. Если Вам нужна помощь, позвоните в отдел обслуживания участников. Отдел обслуживания участников не работает в дни государственных праздников.

- Medicare, включая D-SNP: **1-800-443-0815** (TTY **711**), без выходных с 8:00 до 20:00.
- Medi-Cal: **1-855-839-7613** (TTY **711**), круглосуточно без выходных.
- Любые другие поставщики услуг: **1-800-464-4000** (TTY **711**), круглосуточно без выходных.

Spanish: ATENCIÓN. Se ofrece ayuda en otros idiomas sin ningún costo para usted. Puede solicitar servicios de interpretación, incluyendo intérpretes de lengua de señas. Puede solicitar materiales traducidos a su idioma o en formatos alternativos, como braille, audio o letra grande. También puede solicitar ayuda adicional y dispositivos auxiliares en nuestros centros de atención. Llame al Departamento de Servicio a los Miembros para pedir ayuda. Servicio a los Miembros está cerrado los días festivos principales.

- Medicare, incluyendo D-SNP: **1-800-443-0815** (TTY **711**), los 7 días de la semana, de 8 a. m. a 8 p. m., los 7 días de la semana
- Medi-Cal: **1-855-839-7613** (TTY **711**), las 24 horas del día, los 7 días de la semana.
- Todos los otros: **1-800-788-0616** (TTY **711**), las 24 horas del día, los 7 días de la semana.

Tagalog: PAUNAWA. May magagamit na tulong sa wika nang wala kang babayaran. Maaari kang humiling ng mga serbisyo ng interpreter, kasama ang mga interpreter sa sign language. Maaari kang humiling ng mga babasahin na nakasalin-wika sa iyong wika o sa mga alternatibong format, na tulad ng braille, audio, o malalaking titik. Puwede ka ring humiling ng mga karagdagang tulong at device sa aming mga pasilidad. Tawagan ang aming departamento ng Mga Serbisyo sa Miyembro para sa tulong. Ang mga serbisyo sa miyembro ay sarado sa mga pangunahing holiday.

- Medicare, kasama ang D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. hanggang 8 p.m., 7 araw sa isang linggo
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo
- Ang lahat ng iba: **1-800-464-4000** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo

Thai: ส่งถึง มีบริการให้ความช่วยเหลือด้านภาษา แก่ท่านโดยไม่มีค่าใช้จ่าย ท่านสามารถขอรับบริการล่าม รวมถึงล่ามภาษามือได้ ท่านสามารถขอให้แปลเอกสารเป็นภาษาของท่าน หรือในรูปแบบอื่นๆ เช่นอักษรเบรลล์ ไฟล์เสียง หรือตัวอักษรขนาดใหญ่ ท่านสามารถขอรับอุปกรณ์ ช่วยเหลือและอุปกรณ์เสริมได้ ณ สถานที่ให้บริการของเรา โทรติดต่อฝ่ายบริการสมาชิกของเราเพื่อขอความช่วยเหลือได้ ฝ่ายบริการสมาชิกจะปิดทำการในวันหยุดราชการต่างๆ

- Medicare **รวมถึง** D-SNP: **1-800-443-0815** (TTY **711**) 8.00 **น.** ถึง 20.00 **น.** **หรือ** 7 **วันต่อสัปดาห์**
- Medi-Cal: **1-855-839-7613** (TTY **711**) **ตลอด** 24 **ชั่วโมง หรือ** 7 **วันต่อสัปดาห์**
- **อื่นๆ ทั้งหมด: 1-800-464-4000** (TTY **711**) **ตลอด** 24 **ชั่วโมง หรือ** 7 **วันต่อสัปดาห์**

Ukrainian: УВАГА! Послуги перекладача надаються безкоштовно. Ви можете залишити запит на послуги усного перекладу, зокрема мовою жестів. Ви можете зробити запит на отримання матеріалів, перекладених вашою мовою, або в альтернативних форматах, як-от надрукованим шрифтом Брайля чи великим шрифтом, а також у звуковому форматі. Крім того, ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Якщо вам потрібна допомога, зателефонуйте у відділ обслуговування клієнтів. Відділ обслуговування клієнтів зачинений у державні свята.

- Medicare, зокрема D-SNP: **1-800-443-0815** (TTY **711**), з 8:00 до 20:00, без вихідних.
- Medi-Cal: **1-855-839-7613** (TTY **711**), цілодобово, без вихідних.
- Усі інші надавачі послуг: **1-800-464-4000** (TTY **711**), цілодобово, без вихідних.

Vietnamese: LƯU Ý. Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Quý vị có thể yêu cầu dịch vụ thông dịch, bao gồm cả thông dịch viên ngôn ngữ ký hiệu. Quý vị có thể yêu cầu tài liệu được dịch sang ngôn ngữ của quý vị hay định dạng thay thế, chẳng hạn như chữ nổi braille, băng đĩa thu âm hay bản in khổ chữ lớn. Quý vị cũng có thể yêu cầu các phương tiện và thiết bị phụ trợ tại các cơ sở của chúng tôi. Gọi cho ban Dịch Vụ Hội Viên của chúng tôi để được trợ giúp. Ban dịch vụ hội viên không làm việc vào những ngày lễ lớn.

- Medicare, bao gồm cả D-SNP: **1-800-443-0815** (TTY **711**), 8 giờ sáng đến 8 giờ tối, 7 ngày trong tuần
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần
- Mọi chương trình khác: **1-800-464-4000** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần.

Nondiscrimination Notice

In this document, “we”, “us”, or “our” means Kaiser Permanente (Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., and the Southern California Medical Group). This notice is available on our website at **kp.org**.

Discrimination is against the law. We follow state and federal civil rights laws.

We do not discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call our Member Services department at the numbers below. The call is free. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week.
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week.
- All others: **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week.

Upon request, this document can be made available to you in braille, large print, audio, or electronic formats. To obtain a copy in one of these alternative formats, or another format, call our Member Services department and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with us if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Call our Member Services department. Phone numbers are listed above.
- **By mail:** Download a form at **kp.org** or call Member Services and ask them to send you a form that you can send back.
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at **kp.org/facilities** for addresses)

- **Online:** Use the online form on our website at **kp.org**

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office of Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office of Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

  Office of Civil Rights
  Department of Health Care Services
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  California Department of Health Care Services Office of Civil Rights Complaint forms are available at: http://www.dhcs.ca.gov/Pages/Language_Access.aspx
- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office of Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office of Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
  U.S. Department of Health and Human Services Office of Civil Rights Complaint forms are available at: https://www.hhs.gov/ocr/office/file/index.html
- **Online:** Visit the **Office of Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Southern California Region

EOC #4 - Combined Chiropractic and Acupuncture Services Amendment of the Kaiser Foundation Health Plan, Inc. Evidence of Coverage for
AFFIRM INC

Group ID: 235801 Contract: 1 Version: 6 *EOC* Number: 4 Issue Date: October 21, 2025

January 1, 2026, through December 31, 2026

ASH Plans Customer Service Department
Monday through Friday, hours may vary
1-800-678-9133 (TTY users call **711**) toll free
ashlink.com/ash/kp

TABLE OF CONTENTS FOR EOC #4

Benefit Highlights 1
Introduction 2
Definitions 2
ASH Participating Providers 3
  How to Obtain Services 3
Covered Services 4
  Office Visits 4
  Laboratory Tests and X-rays 5
  Chiropractic Supports and Appliances 5
  Second Opinions 5
  Emergency and Urgent Services Covered Under this Amendment 5
Exclusions 6
Customer Service 6
Grievances 6

Benefit Highlights

We cover the Services described below, subject to exclusions described in the "Exclusions" section, only if all of the following conditions are satisfied:

- You are a Member on the date that you receive the Services
- ASH Plans has determined that the Services are Medically Necessary, except as described in this Amendment
- You receive the Services from ASH Participating Providers or other licensed providers that ASH contracts to provide covered care, except as described in this Amendment

Professional Services (ASH Participating Provider office visits)	**You Pay**
Chiropractic and acupuncture office visits (up to a combined total of 20 visits per 12-month period)	$15 per visit
Other	**You Pay**
X-rays and laboratory tests that are covered Chiropractic Services	No charge
Chiropractic supports and appliances	Amounts in excess of the $50 Allowance

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, refer to the "Covered Services" and "Exclusions" sections.

Introduction

This document amends your Kaiser Foundation Health Plan, Inc. (Health Plan) *EOC* to add coverage for Chiropractic Services and Acupuncture Services as described in this Combined Chiropractic and Acupuncture Services Amendment ("Amendment"). All provisions of the *EOC* apply to coverage described in this document except for the following sections:

- "How to Obtain Services" (except that the "Completion of Services from Non–Plan Providers" section, or for Kaiser Permanente Senior Advantage Members, the "Termination of a Plan Provider's contract and completion of Services" section, does apply to coverage described in this document)
- "Plan Facilities"
- "Emergency Services and Urgent Care"
- "Benefits"

Kaiser Foundation Health Plan, Inc. contracts with American Specialty Health Plans of California, Inc. ("ASH Plans") to make the network of ASH Participating Providers available to you.

When you need chiropractic care or acupuncture, you have direct access to more than 3,000 licensed chiropractors and more than 2,900 licensed acupuncturists in California. You can obtain covered Services from any ASH Participating Provider without a referral from a Plan Physician. Your Cost Share is due when you receive covered Services.

Definitions

In addition to the terms defined in the "Definitions" section of your Health Plan *EOC*, the following terms, when capitalized and used in any part of this Amendment, have the following meanings:

Acupuncture Services: The stimulation of certain points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions and appropriate adjunctive therapies, such as hot/cold packs, infrared heat, or acupressure, when provided during the same course of treatment and in conjunction with acupuncture and when provided by an acupuncturist for the treatment of your Musculoskeletal and Related Disorder, nausea (such as nausea related to chemotherapy, post-surgery nausea, or nausea related to pregnancy), or joint pain (such as lower back, shoulder, or hip joint pain), and headaches.

ASH Participating Provider: One of the following types of providers:

- An acupuncturist who is licensed to provide acupuncture services in California and who has a contract with ASH Plans to provide Medically Necessary Acupuncture Services to you
- A chiropractor who is licensed to provide chiropractic services in California and who has a contract with ASH Plans to provide Medically Necessary Chiropractic Services to you

A list of ASH Participating Providers is available on the ASH Plans website at **ashlink.com/ash/kaisercamedicare** for Kaiser Permanente Senior Advantage Members, or **ashlink.com/ash/kp** for all other Members, or from the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**). The list of ASH Participating Providers is subject to change at any time, without notice. If you have questions, please call the ASH Plans Customer Service Department.

ASH Plans: American Specialty Health Plans of California, Inc., a California corporation.

Chiropractic Services: Chiropractic services include spinal and extremity manipulation and adjunctive therapies such as ultrasound, therapeutic exercise, or electrical muscle stimulation, when provided during the same course of treatment and in conjunction with chiropractic manipulative services, and other services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic supports and appliances) for the treatment of your Musculoskeletal and Related Disorder.

Emergency Acupuncture Services: Covered Acupuncture Services provided for the treatment of a Musculoskeletal and Related Disorder, nausea, or pain, which manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could expect the absence of immediate Acupuncture Services to result in serious jeopardy to your health or body functions or organs.

Emergency Chiropractic Services: Covered Chiropractic Services provided for the treatment of a Musculoskeletal and Related Disorder which manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could expect the absence of immediate Chiropractic Services to result in serious jeopardy to your health or body functions or organs.

Musculoskeletal and Related Disorders: Conditions with signs and symptoms related to the nervous,

muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related manifestations or conditions.

Non–Participating Provider: A provider other than an ASH Participating Provider.

Treatment Plan: One of the following, depending on whether the Treatment Plan is for Chiropractic Services or Acupuncture Services:

- The course of treatment for your Musculoskeletal and Related Disorder, which may include laboratory tests, X-rays, chiropractic supports and appliances, and a specific number of visits for chiropractic manipulations (adjustments) and adjunctive therapies that are Medically Necessary Chiropractic Services for you
- The course of treatment for your Musculoskeletal and Related Disorder, nausea, or pain, which will include a specific number of visits for acupuncture (including adjunctive therapies) that are Medically Necessary Acupuncture Services for you

Urgent Acupuncture Services: Acupuncture Services that meet all of the following requirements:

- They are necessary to prevent serious deterioration of your health resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy
- They cannot be delayed until you return to the Service Area

Urgent Chiropractic Services: Chiropractic Services that meet all of the following requirements:

- They are necessary to prevent serious deterioration of your health resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy
- They cannot be delayed until you return to the Service Area

ASH Participating Providers

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

ASH Plans contracts with ASH Participating Providers and other licensed providers to provide the Services covered under this Amendment (including laboratory tests, X-rays, and chiropractic supports and appliances). You must receive Services covered under this Amendment from an ASH Participating Provider or another licensed provider with which ASH contracts to provide covered care, except for Services covered under "Emergency and Urgent Services Covered Under this Amendment" in the "Covered Services" section and Services that are not available from contracted providers and that are authorized in advance by ASH Plans.

How to Obtain Services

To obtain Services covered under this Amendment call an ASH Participating Provider to schedule an initial examination. If additional Services are required after the initial examination, verification that the Services are Medically Necessary may be required, as described under "Decision time frames" below. Your ASH Participating Provider will request any required medical necessity determinations. An ASH Plans clinician in the same or similar specialty as the provider of Services under review will determine whether the Services are or were Medically Necessary Services.

Decision time frames

The ASH Plans' clinician will make the authorization decision within the time frame appropriate for your condition, but no later than five business days after receiving all of the information (including additional examination and test results) reasonably necessary to make the decision, except that decisions about urgent Services will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision. If ASH Plans needs more time to make the decision because it doesn't have information reasonably necessary to make the decision, or because it has requested consultation by a particular specialist, you and your ASH Participating Provider will be informed in writing about the additional information, testing, or specialist that is needed, and the date that ASH Plans expects to make a decision.

Your ASH Participating Provider will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your ASH Participating Provider will be informed of the scope of the authorized Services. If ASH Plans does not authorize all of the Services, ASH Plans will send you a written decision and explanation, including the rationale for the decision and the criteria used to make the decision, within two business days after the decision is made. The letter will also include information about your appeal rights, which are

described in the "Coverage Decisions, Appeals, and Complaints" section of your Health Plan *EOC* for Kaiser Permanente Senior Advantage Members, and "Dispute Resolution" section of your Health Plan *EOC* for all other Members. Any written criteria that ASH Plans uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request. If you have questions or concerns, please contact ASH Plans or Kaiser Permanente as described under "Customer Service" in this Amendment.

Covered Services

We cover the Services listed in this "Covered Services" section, subject to exclusions described in the "Exclusions" section, only if all of the following conditions are satisfied:

- You are a Member on the date that you receive the Services
- ASH Plans has determined that the Services are Medically Necessary, except for:
  - the initial examination described under "Office Visits" in this "Covered Services" section
  - Services covered under "Emergency and Urgent Services Covered Under this Amendment" in this "Covered Services" section
- You receive the Services from ASH Participating Providers or other licensed providers with which ASH contracts to provide covered care, except for:
  - Services covered under "Emergency and Urgent Services Covered Under this Amendment" in this "Covered Services" section
  - Services that are not available from ASH Participating Providers or other licensed providers with which ASH contracts to provide covered care and that are authorized in advance by ASH Plans

When you receive covered Services, you must pay the Cost Share listed in this "Covered Services" section. If you receive Services that are not covered under this Amendment, you may be liable for the full price of those Services.

Note: If Charges for Services are less than the Copayment described in this "Covered Services" section, you will pay the lesser amount.

The Cost Share you pay for Services covered under this Amendment does not apply toward any Plan Deductible or Plan Out-of-Pocket Maximum described in your Health Plan *EOC*.

If you have questions about your Cost Share for specific Services that you are scheduled to receive or that your provider orders during a visit or procedure, please call the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**) weekdays, hours may vary.

Coverage of Acupuncture Services under this Amendment is different from the coverage of acupuncture Services under your Health Plan *EOC*. You do not need a referral to get covered Services under this Amendment, but covered Services and your Cost Share may differ from those under your Health Plan *EOC*. If you receive acupuncture Services for which you have a referral (as described under "Getting a Referral" in the "How to Obtain Services" section of the *EOC*), then unless you tell us otherwise, we will assume that you are using your coverage under your Health Plan *EOC*.

If you are a Kaiser Permanente Senior Advantage Member, refer to your Health Plan *EOC* for information about the chiropractic Services that we cover in accord with Medicare guidelines, which are separate from the Services covered under this Amendment.

Office Visits

We cover up to a combined total of 20 of the following types of office visits per 12-month period at **a $15 Copayment per visit:**

- **Initial chiropractic examination:** An examination performed by an ASH Participating Provider to determine the nature of your problem (and, if appropriate, to prepare a Treatment Plan), and to provide Medically Necessary Chiropractic Services, which may include an adjustment and adjunctive therapy. We cover an initial examination only if you have not already received covered Chiropractic Services from an ASH Participating Provider in the same 12-month period for your Musculoskeletal and Related Disorder
- **Subsequent chiropractic office visits:** Subsequent ASH Participating Provider office visits for Chiropractic Services that are determined to be Medically Necessary by an ASH Plans clinician. These subsequent office visits may include an adjustment, adjunctive therapy, and a re-examination to assess the need to continue, extend, or change a Treatment Plan
- **Initial acupuncture examination:** An examination performed by an ASH Participating Provider to determine the nature of your problem (and, if appropriate, to prepare a Treatment Plan), and to provide Medically Necessary Acupuncture Services.

We cover an initial examination only if you have not already received covered Acupuncture Services from an ASH Participating Provider in the same 12-month period for your Musculoskeletal and Related Disorder, nausea, or pain

- **Subsequent acupuncture office visits:** Subsequent ASH Participating Provider office visits for Acupuncture Services that are determined to be Medically Necessary by an ASH Plans clinician, which may include a re-examination to assess the need to continue, extend, or change a Treatment Plan

Each office visit counts toward any visit limit, if applicable.

Laboratory Tests and X-rays

We cover Medically Necessary laboratory tests and X-rays when prescribed as part of covered chiropractic care described under "Office Visits" in this "Covered Services" section at **no charge** when an ASH Participating Provider provides the Services or refers you to another licensed provider with which ASH contracts to provide covered Services.

Chiropractic Supports and Appliances

We provide a **$50 Allowance per 12-month period** toward the ASH Plans fee schedule price for chiropractic appliances listed in this paragraph when the item is prescribed and provided to you by an ASH Participating Provider as part of covered chiropractic care described under "Office Visits" in this "Covered Services" section. If the price of the items in the ASH Plans fee schedule exceeds $50 (the Allowance), you will pay the amount in excess of $50 (and that payment does not apply toward the Plan Out-of-Pocket Maximum described in your Health Plan *EOC*). Covered chiropractic appliances are limited to: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle braces, knee braces, rib supports, and wrist braces.

Second Opinions

You may request a second opinion in regard to covered Services by contacting another ASH Participating Provider. Your visit to another ASH Participating Provider for a second opinion generally will count toward any visit limit, if applicable. An ASH Participating Provider may also request a second opinion in regard to covered Services by referring you to another ASH Participating Provider in the same or similar specialty. If you are referred by an ASH Participating Provider to another ASH Participating Provider, or you see an ASH Participating Provider for lab work or an X-ray, your visit to the other ASH Participating Provider will not count toward any visit limit. An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial, and of your right to file a grievance as described under "Grievances" in this Amendment.

Emergency and Urgent Services Covered Under this Amendment

Emergency and urgent chiropractic Services

We cover Emergency Chiropractic Services and Urgent Chiropractic Services provided by an ASH Participating Provider or a Non–Participating Provider at **a $15 Copayment per visit**. We do not cover follow-up or continuing care from a Non-Participating Provider unless ASH Plans has authorized the Services in advance. Also, we do not cover Services from a Non-Participating Provider that ASH Plans determines are not Emergency Chiropractic Services or Urgent Chiropractic Services.

Emergency and urgent acupuncture Services

We cover Emergency Acupuncture Services and Urgent Acupuncture Services provided by an ASH Participating Provider or a Non–Participating Provider at **a $15 Copayment per visit**. We do not cover follow-up or continuing care from a Non–Participating Provider unless ASH Plans has authorized the Services in advance. Also, we do not cover Services from a Non-Participating Provider that ASH Plans determines are not Emergency Acupuncture Services or Urgent Acupuncture Services.

How to file a claim

As soon as possible after receiving Emergency Chiropractic Services or Urgent Chiropractic Services or Emergency Acupuncture Services or Urgent Acupuncture Services, you must file an ASH Plans claim form. To request a claim form or for more information, please call ASH Plans toll free at **1-800-678-9133** (TTY users call **711**) or visit the ASH Plans website at **ashlink.com**. You must send the completed claim form to:

ASH Plans
P.O. Box 509002
San Diego, CA 92150-9002

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage under this Amendment. (Note: Some items and services listed in this "Exclusions" section may be covered Services under your Health Plan *EOC*. Please refer to your Health Plan *EOC* for details.) These exclusions apply to all Services that would otherwise be covered under this Amendment regardless of whether the services are within the scope of a provider's license or certificate:

- Acupuncture services for conditions other than Musculoskeletal and Related Disorders, nausea, and pain
- Acupuncture performed with reusable needles
- Services provided by an acupuncturist that are not within the scope of licensure for an acupuncturist licensed in California
- For Acupuncture Services, adjunctive therapies unless provided during the same course of treatment and in conjunction with acupuncture
- Services provided by a chiropractor that are not within the scope of licensure for a chiropractor licensed in California
- For Chiropractic Services, adjunctive therapy not associated with spinal, muscle, or joint manipulations
- Air conditioners, air purifiers, therapeutic mattresses, chiropractic appliances, durable medical equipment, supplies, devices, appliances, and any other item except those listed as covered under "Chiropractic Supports and Appliances" in the "Covered Services" section of this Amendment
- Services for asthma or addiction, such as nicotine addiction
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Thermography
- Experimental or investigational Services. If coverage for a Service is denied because it is experimental or investigational and you want to appeal the denial, refer to your Health Plan *EOC* for information about the appeal process
- CT scans, MRIs, PET scans, bone scans, nuclear medicine, and any other type of diagnostic imaging or radiology other than X-rays covered under the "Covered Services" section of this Amendment
- Ambulance and other transportation
- Education programs, non-medical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
- Services for pre-employment physicals or vocational rehabilitation
- Drugs and medicines, including non-legend or proprietary drugs and medicines
- Services you receive outside the state of California, except for Services covered under "Emergency and Urgent Services Covered Under this Amendment" in the "Covered Services" section
- Hospital services, anesthesia, manipulation under anesthesia, and related services
- Dietary and nutritional supplements, such as vitamins, minerals, herbs, herbal products, injectable supplements, and similar products
- Massage therapy
- Maintenance care (services provided to Members whose treatment records indicate that they have reached maximum therapeutic benefit)

Customer Service

If you have a question or concern regarding the Services you received from an ASH Participating Provider or any other licensed provider with which ASH contracts to provide covered Services, you may call the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**) weekdays, hours may vary, or write ASH Plans at:

ASH Plans
Customer Service Department
P.O. Box 509002
San Diego, CA 92150-9002

Grievances

You can file a grievance with Kaiser Permanente regarding any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about Services you received. If you are a Kaiser Permanente Senior Advantage Member, you may submit your grievance orally or in writing to Kaiser Permanente as described in the "Coverage Decisions, Appeals, and Complaints" section of your Health Plan *EOC.* Otherwise, you may submit your grievance orally or in writing to Kaiser Permanente as described in the "Dispute Resolution" section of your Health Plan *EOC*.