**January 1 – December 31, 2027**

# Evidence of Coverage for 2027:

## Your Medicare Health Benefits and Services as a Member of Kaiser Permanente Medicare Advantage Liberty (HMO)

This document gives the details of your Medicare health coverage from January 1 – December 31, 2027. **This is an important legal document. Keep it in a safe place.**

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

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

**For questions about this document, call Member Services at 1-888-777-5536 (TTY users call 711). Hours are 8 a.m. to 8 p.m., 7 days a week. This call is free.**

This plan, Kaiser Permanente Medicare Advantage Liberty, is offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan). When this *Evidence of Coverage* says "we," "us," or "our," it means Health Plan. When it says "plan" or "our plan," it means Kaiser Permanente Medicare Advantage Liberty (Kaiser Permanente Medicare Advantage).

This document is available for free in Spanish.

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

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2028.

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

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KAISER PERMANENTE®

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# CHAPTER 1: Get started as a member

## SECTION 1 You're a member of Kaiser Permanente Medicare Advantage Liberty

### Section 1.1 You're enrolled in Kaiser Permanente Medicare Advantage Liberty which is a Medicare HMO

You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, Kaiser Permanente Medicare Advantage Liberty. Our plan covers all Part A and Part B services. However, cost-sharing and provider access in this plan are different from Original Medicare.

Kaiser Permanente Medicare Advantage Liberty is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company. Kaiser Permanente Medicare Advantage Liberty plan *doesn't* include Part D drug coverage.

### Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how we cover your care. Other parts of this contract include your enrollment form and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in Kaiser Permanente Medicare Advantage Liberty between January 1, 2027, and December 31, 2027.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of our plan after December 31, 2027. We can also choose to stop offering our plan in your service area, after December 31, 2027.

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

## SECTION 2 Plan eligibility requirements

### Section 2.1 Eligibility requirements

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

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it
- You're a United States citizen or national, or an eligible noncitizen.

### Section 2.2 Plan service area for Kaiser Permanente Medicare Advantage Liberty

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

Our service area includes the following:

- The **District of Columbia**.
- These counties in Virginia: **Arlington, Fairfax, Loudoun, Prince William, Spotsylvania, and Stafford**.
- These independent cities in Virginia: **Alexandria, City of Falls Church, Fairfax, Fredericksburg City, Manassas, and Manassas Park**.
- These counties in Maryland: **Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, Howard, Montgomery, and Prince George's**.
- These parts of counties in Maryland, in the following ZIP codes only:
  - **Calvert County:** 20639, 20678, 20689, 20714, 20732, 20736, and 20754.
  - **Charles County:** 20601–4, 20607, 20612–13, 20616–17, 20637, 20640, 20643, 20645–46, 20658, 20675, 20677, and 20695.
  - **Frederick County:** 20842, 20871, 21701–05, 21709–10, 21714, 21716–18, 21754–55, 21757–59, 21762, 21769–71, 21774–77, 21787, and 21790–93.

If you move out of our plan's service area, you can't stay a member of this plan. Call Member Services at 1-888-777-5536 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health plan in your new location.

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

### Section 2.3 U.S. citizen or national, or eligible noncitizen

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

## SECTION 3 Important membership material

### Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan. You should also show the provider your Medicaid card, if you have one. Sample membership card:




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

If our plan membership card is damaged, lost, or stolen, call Member Services at 1-888-777-5536 (TTY users call 711) right away and we'll send you a new card.

### Section 3.2 *Provider Directory*

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

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

Get the most recent list of providers and suppliers on our website at kp.org/directory.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Member Services at 1-888-777-5536 (TTY users call 711). Requested paper *provider directories* will be mailed to you within 3 business days.

## SECTION 4 Summary of Important Costs for 2027

| | Your Costs in 2027 |
|---|---|
| **Monthly plan premium*** <br> * Your premium can be higher or lower than this amount. Go to Section 4.1 for details. | **$0** |
| **Maximum out-of-pocket amount** <br> This is the most you'll pay out-of-pocket for covered Part A and Part B services. <br> (Go to Chapter 4, Section 1 for details.) | **$5,900** |
| **Primary care office visits** | **$0** |
| **Specialist office visits** | **$40 per visit** |
| **Inpatient hospital stays** <br> Includes various inpatient hospital stays such as acute care rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged. | **Per admission, $295 per day for days 1–6 ($0 for the rest of your stay)** |

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Optional Supplemental Benefits Premium (Section 4.3)

### Section 4.1 Plan premium

You don't pay a separate monthly plan premium for Kaiser Permanente Medicare Advantage Liberty.

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, check your copy of the *Medicare & You 2027* handbook in the section called *2027 Medicare Costs.* Download a copy from the Medicare website (Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), TTY users call 1-877-486-2048.

### Section 4.2 Monthly Medicare Part B Premium

**Many members are required to pay other Medicare premiums**

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

### Section 4.3 Optional Supplemental Benefits Premium

If you signed up for extra benefits, also called *optional supplemental benefits,* you pay an additional premium each month for these extra benefits. Go to Chapter 4, Section 2.1 for details.

The monthly premium for optional supplemental benefits (Advantage Plus) is **$18** for Option 1, **$23** for Option 2, or **$41** for both Options 1 and 2.

## SECTION 5 More information about your monthly plan premium

### Section 5.1 How to pay your plan premium

There are four ways you can pay your plan premium.

**Option 1: Pay by check**

You may pay by check and mail your monthly plan premium directly to us. We must receive your check (or money order) made payable to "Kaiser Permanente" on or before the last day

of the month preceding the month of coverage at the following address, or the address on your invoice if it's different:

Kaiser Foundation Health Plan
P.O. Box 7158
Pasadena, CA 91109-7158

**Note:** You cannot pay in person. If your bank does not honor your payment, we will bill you a returned item charge.

**Option 2: You can sign up for monthly automatic payment**

If you prefer, you can have your monthly plan premium automatically withdrawn from your bank account or charged to your credit card. If you select automatic plan premium payment, your monthly plan premium is automatically paid from your bank account (checking or savings account) or credit card. The transaction will appear on your monthly bank or credit card statement, serving as your permanent record of payment.

Please call Member Services to set up your credit card payment, request a Medicare Autopay Selection Form to set up a bank account withdrawal, or if you have any questions.

You can also manage autopay options, including signing up for autopay, at kp.org/payonline.

**Option 3: You can make a one-time payment by phone or online**

You can make a one-time payment by credit or debit card online at kp.org/payonline or by calling 1-888-255-1400, 7 days a week, 24 hours a day. You will need your Kaiser Permanente account information from your bill to make a payment.

**Option 4: Have plan premiums deducted from your monthly Social Security check**

You can have your plan premium taken out of your monthly Social Security check. Contact Member Services for more information about how to pay your plan premium this way. We will be happy to help you set this up.

**Changing the way you pay your plan premium.** If you decide to change how you pay your plan premium, it can take up to 3 months for your new payment method to take effect. While we process your new payment method, you're still responsible for making sure your plan premium is paid on time. To change your payment method, call Member Services or sign up for an automatic payment option or make a one-time payment online.

If you don't select an automatic payment option, you will have the option to pay your invoice by mail, phone, or online. You will receive an invoice for the payment option selected. If you do not want to receive an invoice, log onto kp.org to update your preferences to online billing. After you receive your first bill, you can choose a different payment option.

**If you have trouble paying your plan premium**

Your plan premium is due in our office by the last day of the bill generation month.

If we don't get your payment by the due date, we'll send you a notice letting you know the amount you owe.

If you have trouble paying your premium on time, call Member Services at 1-888-777-5536 (TTY users call 711) to see if we can direct you to programs that will help with your costs.

We have the right to pursue collections of any premiums you owe. If we don't receive your premium payment within 60 days and you are enrolled in our optional supplemental benefits package (Advantage Plus), we may terminate those benefits and you will not be able to sign up for the benefits again until October 15 for coverage to become effective January 1.

If you think we wrongfully ended your membership, you can make a complaint (also called a grievance). If you had an emergency circumstance out of your control that made you unable to pay your plan premium within our grace period, you can make a complaint. For complaints, we'll review our decision again. Go to Chapter 7 to learn how to make a complaint or call us at 1-888-777-5536 between 8 a.m. to 8 p.m., 7 days a week. TTY users call 711. You must make your complaint no later than 60 calendar days after the date your membership ends.

### Section 5.2 Your monthly plan premium won't change during the year

We're not allowed to change your plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September and the new premium will take effect on January 1.

## SECTION 6 Keep your plan membership record up-to-date

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

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

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

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)

- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you participate in a clinical research study (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Member Services at 1-888-777-5536 (TTY users call 711).

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

## SECTION 7 How other insurance works with our plan

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

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services at 1-888-777-5536 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):

    - If you're under 65 and disabled and you (or your family member) are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
    - If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

# CHAPTER 2:
# Phone numbers and resources

## SECTION 1 Kaiser Permanente Medicare Advantage Liberty contacts

For help with claims, billing, or member card questions, call or write to our plan. We'll be happy to help you.

| Member Services – Contact Information | |
|---|---|
| **Call** | 1-888-777-5536<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.<br>Member Services at 1-888-777-5536 (TTY users call 711) also has free language interpreter services for non-English speakers. |
| **TTY** | 711<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. |
| **Write** | Kaiser Permanente<br>Member Services<br>Nine Piedmont Center<br>3495 Piedmont Road, NE<br>Atlanta, GA 30305-1736 |
| **Website** | kp.org |

### How to ask for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services.

For more information on how to ask for coverage decisions or make a complaint about your medical care, go to Chapter 7.

| Coverage Decisions for Medical Care – Contact Information | |
|---|---|
| **Call** | 1-888-777-5536<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. |

| Coverage Decisions for Medical Care – Contact Information | |
|---|---|
| **TTY** | 711<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. |
| **Fax** | 1-800-660-2019 |
| **Write** | Kaiser Permanente<br>New Carrollton Administrative Office<br>Attention: Utilization Management Department<br>4000 Garden City Drive<br>New Carrollton, MD 20785 |
| **Website** | kp.org |

### How to ask for an appeal about your medical care

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 medical care, go to Chapter 7.

| Appeals or Complaints about Medical Care – Contact Information | |
|---|---|
| **Call** | 1-888-777-5536<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. |
| **TTY** | 711<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. |
| **Fax** | 1-404-949-5001 |
| **Write** | Kaiser Permanente<br>Member Relations<br>Nine Piedmont Center<br>3495 Piedmont Road, NE<br>Atlanta, GA 30305-1736 |
| **Website** | kp.org |

| Appeals or Complaints about Medical Care – Contact Information | |
|---|---|
| **Medicare website** | To submit a complaint about our plan directly to Medicare, go to Medicare.gov/my/medicare-complaint. |

**How to ask us to pay our share of the cost for medical care you got**

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 5 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7 for more information.

| Payment Requests – Contact Information | |
|---|---|
| **Call** | 1-888-777-5536<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. |
| **TTY** | 711<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. |
| **Write** | Kaiser Permanente<br>Claims Department<br>Mid-Atlantic States Region<br>P.O. Box 371860 Denver, CO 80237-9998 |
| **Website** | kp.org |

## SECTION 2 Get help from Medicare

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

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

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

## SECTION 3 State Health Insurance Assistance Program (SHIP)

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

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

- In the District of Columbia, the SHIP is called DC Department of Aging and Community Living.
- In Maryland, the SHIP is called Maryland Department of Aging.
- In Virginia, the SHIP is called Virginia Insurance Counseling and Assistance Program.

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

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

| **Department of Aging and Community Living (District of Columbia's Health Insurance Counseling) – Contact Information** | |
|---|---|
| **Call** | 1-202-727-8370 |
| **TTY** | 711 |
| **Write** | 500 K Street N.E., Washington, DC 20002 |
| **Website** | dcoa.dc.gov/service/health-insurance-counseling |

| **Maryland Department of Aging – Contact Information** | |
|---|---|
| **Call** | 1-410-767-1100 or toll free 1-800-243-3425 |
| **TTY** | 711 |
| **Write** | 301 West Preston St., Suite 1007, Baltimore, MD 21201 |
| **Website** | https://aging.maryland.gov/Pages/default.aspx |

| Virginia Insurance Counseling and Assistance Program– Contact Information | |
|---|---|
| **Call** | 1-804-662-9333 or toll free 1-800-552-3402 |
| **TTY** | 711 |
| **Write** | 1610 Forest Avenue, Suite 100, Henrico, VA 23229 |
| **Website** | vda.virginia.gov |

## SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For the District of Columbia, Maryland, and Virginia, the Quality Improvement Organization is called Commence Health.

Commence Health has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. 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 (District of Columbia's, Maryland's, and Virginia's Quality Improvement Organization) – Contact Information | |
|---|---|
| **Call** | 1-888-396-4646<br>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. |

| **Commence Health (District of Columbia's, Maryland's, and Virginia's Quality Improvement Organization) – Contact Information** | |
|---|---|
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. |
| **Write** | BFCC-QIO Program<br>Commence Health LLC<br>PO Box 2687<br>Virginia Beach, VA 23450 |
| **Website** | https://www.livantaqio.cms.gov/en |

## SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

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

## SECTION 6 Medicaid

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

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

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

To find out more about Medicaid and Medicare Savings Programs, contact Medicaid agency for your state listed below.

| **Department of Healthcare Finance (District of Columbia's Medicaid program) – Contact Information** | |
|---|---|
| **Call** | 1-202-442-5988<br>Monday through Friday, 8:15 a.m. to 4:45 p.m. |
| **TTY** | 711 |
| **Write** | 441 4th Street NW, 900S, Washington, DC 20001 |
| **Website** | dhcf.dc.gov |

| **Maryland Medical Assistance Program/HealthChoice - Contact Information** | |
|---|---|
| **Call** | 1-410-767-5800 or 1-877-463-3464<br>Monday through Friday, 8 a.m. to 5 p.m. |
| **TTY** | 1-800-735-2258<br>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. |
| **Write** | Contact the Department of Social Services (DSS) in the city or county where you live. |

| Maryland Medical Assistance Program/HealthChoice - Contact Information | |
|---|---|
| **Website** | mmcp.dhmh.maryland.gov |

| Virginia Department of Medical Assistance Services – Contact Information | |
|---|---|
| **Call** | 1-804-786-6145<br>Monday through Friday, 8 a.m. to 5 p.m. |
| **TTY** | 1-800-343-0634<br>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. |
| **Write** | Contact the Department of Social Services (DSS) in the city or county where you live. |
| **Website** | dmas.virginia.gov |

## SECTION 7 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<br>Calls to this number are free.<br>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.<br>Press "1" to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays. |

| Railroad Retirement Board (RRB) – Contact Information | |
|---|---|
| **TTY** | 1-312-751-4701<br>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.<br>Calls to this number aren't free. |
| **Website** | https://RRB.gov |

## SECTION 8 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at 1-888-777-5536 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

# CHAPTER 3:
# Using our plan for your medical services

## SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered.

For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

### Section 1.1 Network providers and covered services

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

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

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

We will generally cover your medical care as long as:

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

- In most situations, your network PCP must give you approval in advance (a referral) before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information, go to Section 2.3.
- You don't need referrals from your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2.

- **You must get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means you have to pay the provider in full for services you get. *Here are 4 exceptions:*
  - Our plan covers emergency or urgently needed services you get from an out-of-network provider. For more information and to see what emergency or urgently needed services are, go to Section 3.
  - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost-sharing you normally pay in-network if we or our Medical Group authorize the services before you get the care. In this situation, you pay the same as you pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
  - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost-sharing you pay our plan for dialysis can never be higher than the cost-sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider outside our plan's network, your cost-sharing can't be higher than the cost-sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost-sharing for the dialysis may be higher.
  - If you receive care from network providers in other Kaiser Permanente regions described in Section 2.4 in this chapter.

## SECTION 2 Use providers in our plan's network to get medical care

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

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

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

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

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

### How to choose or change your PCP

As explained above, your PCP plays an important role in your health care. That's why we require you to have a PCP. If you do not select a PCP when you enroll, we will assign you a physician and notify you accordingly.

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers, and you'd need to choose a new PCP. Your PCP selections will be effective immediately.

To choose or change your PCP, please call Member Services or visit kp.org/doctor.

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

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

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

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

- Routine women's health care, including breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider
- Flu shots, COVID-19 vaccines, Hepatitis B vaccines, and pneumonia vaccines, as long as you get them from a network provider
- Emergency services from network providers or from out-of-network providers
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area. If possible, call Member Services at 1-888-777-5536 (TTY users call 711) before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.
- Kidney disease education visits, as long as you receive services from a network provider
- Preventive dental care, as long as you receive services from a network provider
- Preventive care, except for abdominal aortic aneurysm screening, bone mass measurement, cardiovascular screening, colorectal cancer screening, and medical nutrition therapy

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

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

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

### Referrals from your PCP

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

### Referrals to network providers

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

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

### Prior authorization

For the services and items listed below, your network provider will need to get approval in advance from our plan or Medical Group (this is called getting "prior authorization"). Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals. If you ever disagree with authorization decisions, you can file an appeal as described in Chapter 7.

- Services and items identified in Chapter 4 with a footnote (†).
- For certain network specialty care, your PCP will need to request that we authorize the referral before you can see the specialty care network provider. If we authorize the referral, it will be for a specific treatment plan as explained above (see "Referrals to network providers" for details).
- If your network provider decides that you require covered services not available from network providers, he or she will recommend to Medical Group that you be referred to an out-of-network provider inside or outside our service area. The appropriate Medical Group designee will authorize the services if he or she determines that the covered services are medically necessary and are not available from a network provider. Referrals to out-of-network providers will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. It specifies the duration of the referral without having to get additional approval from us. Please ask your network provider what services have been authorized if you are not certain. If the out-of-network specialist wants you to come back for more care, be sure to check if the referral covers the additional care. If it doesn't, please contact your network provider.

- After we are notified that you need post-stabilization care from an out-of-network provider following emergency care, we will discuss your condition with the out-of-network provider. If we decide that you require post-stabilization care and that this care would be covered if you received it from a network provider, we will authorize your care from the out-of-network provider only if we cannot arrange to have a network provider (or other designated provider) provide the care. Please see Section 3.1 in this chapter for more information.
- Medically necessary transgender surgery and associated procedures.
- Medically necessary bariatric surgery.
- Care from a religious non medical health care institution described in Section 6 of this chapter.
- If your network provider makes a written or electronic referral for a transplant, the Medical Group's regional transplant advisory committee and National Transplant Services (NTS) will authorize the services if it determines that they are medically necessary or covered in accord with Medicare guidelines. In cases where no transplant committee or board exists, Medical Group will refer you to physician(s) at a transplant Center of Excellence. An authorization will be issued for medically necessary transplant services or covered in accord with Medicare guidelines in collaboration with the Kaiser Permanente Referring Specialist and the Transplant Team at the Center of Excellence.
- For nonemergency inpatient admissions, Medical Group and our plan will coordinate your care and determine which hospital or facility you will be admitted. Your network provider must receive prior authorization from us for nonemergency admissions, including admissions to behavioral health, skilled nursing facilities, inpatient rehabilitation or other inpatient settings. We will determine the most appropriate facility for care. Depending upon your medical needs, we may transfer you from one network hospital or other inpatient setting, to another network hospital where Medical Group physicians are always on duty. In addition, we may transfer you from one network skilled nursing facility to another where Medical Group physicians make rounds and are available for urgent care.

**When a specialist or another network provider leaves our plan**

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

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.

  - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
  - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost-sharing. Please contact us so we can authorize the services.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider, or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both. (Go to Chapter 7.)

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

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

- Emergency or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services mean, see Section 3 in this chapter.
- We or Medical Group authorize a referral to an out-of-network provider described in Section 2.3 of this chapter.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area.
- If you visit the service area of another Kaiser Permanente region, you can receive certain care covered under this *Evidence of Coverage* from designated providers in that service area. Please call our Care Away From Home travel line at 1-951-268-3900 (TTY 711), 24 hours a day, 7 days a week (except holidays), or visit our website at kp.org/travel for more information about getting care when visiting another Kaiser

Permanente Region's service area, including coverage information and facility locations. **Note:** Our Care Away From Home travel line can also answer questions about covered emergency or urgent care services you receive out-of-network, including how to get reimbursement.

## SECTION 3 How to get services in an emergency, disaster, or urgent need for care

### Section 3.1 Get care if you have a medical emergency

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere inside or outside the United States.

- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The number to call is listed on the back of your plan membership card.

**Covered services in a medical emergency**

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

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

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

out-of-network provider. In most cases, you will only be held financially liable if you are notified by the out-of-network provider or us about your potential liability.

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

**What if it wasn't a medical emergency?**

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

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

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

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

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

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. Whether you are calling for advice or to make an appointment, you can speak to an advice nurse.

They can often answer questions about a minor concern, tell you what to do if a network facility is closed, or advise you about what to do next, including making a same-day urgent care appointment for you if it's medically appropriate. To speak with an advice nurse 24 hours a day, 7 days a week or make an appointment, please call 1-800-777-7904 (TTY 711), or refer to your *Provider Directory* for appointment and advice telephone numbers.

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

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

### Section 3.3 Get care during a disaster

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

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

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

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

If you paid more than our plan cost-sharing for covered services, or if you get a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 5 for information about what to do.

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

Our plan covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan or you get services out-of-network without authorization that are not emergency or urgently needed services, you're responsible for paying the full cost of services.

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

## SECTION 5 Medical services in a clinical research study

### Section 5.1 What is a clinical research study

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

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

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

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

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

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

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

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

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost-sharing in Original Medicare and your in-network cost-sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost-sharing you paid. Go to Chapter 5 for more information on submitting requests for payments.

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

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

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

### Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication Medicare and Clinical Research Studies available at Medicare.gov/coverage/clinical-research-studies. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

## SECTION 6 Rules for getting care in a religious non-medical health care institution

### Section 6.1 A religious non-medical health care institution

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

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

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

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

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

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

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

## SECTION 7 Rules for ownership of durable medical equipment

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

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

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

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

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

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

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

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

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

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

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

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

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for applicable cost-sharing for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

# CHAPTER 4:
# Medical Benefits Chart (what's covered and what you pay)

## SECTION 1 Understanding your out-of-pocket costs for covered services

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of our plan. This section also gives information about medical services that aren't covered. It also explains limits on certain services. In addition, please see Chapter 3, Chapter 9, and Chapter 10 for additional coverage information, including limitations (for example, coordination of benefits, durable medical equipment, home health care, skilled nursing facility care, and third party liability). Section 2.1 in this chapter describes our optional supplemental benefits.

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

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

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

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

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

Medicare Advantage Plans have limits on the total amount you have to pay out-of-pocket each year for in-network medical services covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2027 the MOOP amount is $5,900**.

The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These services are marked with an asterisk **(*)** in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of **$5,900**, you won't have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

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

Here's how protection from balance billing works:

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15), you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
    - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
    - If you get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or for urgently needed services outside the service area.)
- If you think a provider has balance billed you, call Member Services at 1-888-777-5536 (TTY users call 711).

## SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

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

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

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay less. (To learn more about the coverage and costs of Original

Medicare, go to your *Medicare & You 2027* handbook. View it online at Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.)

- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.

 This apple shows preventive services in the Medical Benefits Chart.

## Medical Benefits Chart

| Covered Service | What you pay |
|---|---|
| **Abdominal aortic aneurysm screening†**<br>A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS). | There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. |
| **Acupuncture for chronic low back pain†**<br>Covered services include:<br>Up to 12 visits in 90 days are covered under the following circumstances:<br>For the purpose of this benefit, chronic low back pain is defined as:<br>• Lasting 12 weeks or longer<br>• Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.)<br>• Not associated with surgery<br>• Not associated with pregnancy<br>An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.<br>Treatment must be discontinued if the patient is not improving or is regressing.<br>**Provider Requirements:**<br>Physicians may furnish acupuncture in accordance with applicable state requirements.<br>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs), and auxiliary | **$0** |

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

| Covered Service | What you pay |
|---|---|
| personnel may furnish acupuncture if they meet all applicable state requirements and have:<br>• a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,<br>• a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia.<br>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by regulations. | |
| **Ambulance services**<br>Covered ambulance services, whether for an emergency or non-emergency† situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.<br>We also cover the services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) if you reasonably believe that you have an emergency medical condition and you reasonably believe that your | **$250** per one-way trip |

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

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

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

| Covered Service | What you pay |
|---|---|
| • One screening mammogram every 12 months for women aged 40 and older<br>• Clinical breast exams once every 24 months | |
| **Cardiac rehabilitation services†**<br>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan covers these comprehensive programs if you've had at least one of these conditions:<br>• Heart attack in the last 12 months<br>• Coronary artery bypass surgery<br>• Stable angina pectoris (chest pain)<br>• Heart valve repair or replacement<br>• Coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open)<br>• Heart or heart and lung transplant<br>• Stable chronic heart failure<br>Coverage limitations:<br>You can get up to 36 cardiac rehabilitation sessions. You can have 2 sessions per day (each lasting 1 hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period. | **$40** per visit |
| **Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)**<br>We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood | There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. |

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

| Covered Service | What you pay |
|---|---|
| pressure, and give you tips to make sure you're eating healthy. | |
| **Cardiovascular disease screening tests†**<br>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). | There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. |
| **Cervical and vaginal cancer screening**<br>Covered services include:<br>• Pap tests and pelvic exams once every 24 months for all women<br>• One pap test every 12 months if at high risk of cervical or vaginal cancer or if of childbearing age and have had an abnormal pap test within the past 3 years | There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. |
| **Chiropractic services†**<br>Covered services include:<br>• We cover only manual manipulation of the spine to correct a vertebral subluxation<br>  ○ These Medicare-covered services are provided by a network chiropractor. For the list of network chiropractors, please refer to the *Provider Directory* | **$0** per visit |
| **Colorectal cancer screening†**<br>The following screening tests are covered:<br>• Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal | There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.<br>If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible |

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

| Covered Service | What you pay |
|---|---|
| cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy.<br>• Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, coverage of a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed.<br>• Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography.<br>• Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.<br>• Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.<br>• Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.<br>• Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. | sigmoidoscopy, the screening exam becomes a diagnostic exam and you pay **$0** for the doctor's services. |

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

| Covered Service | What you pay |
|---|---|
| • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test. | |
| • Procedures performed during a screening colonoscopy (for example, removal of polyps).†<br>• Colonoscopies following a positive gFOBT or FIT test or a flexible sigmoidoscopy screening.†<br>**Note:** All other colonoscopies are subject to the applicable cost-sharing listed elsewhere in this chart. | **$0** |
| **Dental services – Medicare†**<br>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. | **$40** per visit |
| **Dental services – non-Medicare***<br>**Preventive dental care**<br>We cover preventive dental services when performed by participating LIBERTY Dental Plan providers and subject to the exclusions and limitations, including visit limits, described in Section 3.1 of this chapter. Covered services include:<br>• Periodic oral evaluation (D0120) – limited to two per calendar year. | **$0** |

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

| Covered Service | What you pay |
|---|---|
| • Limited oral evaluation – problem focused (D0140).<br>• Comprehensive oral evaluation – new or established patient (D0150) – limited to once per three calendar years.<br>• Prophylaxis (D1110) – limited to two per calendar year. One additional for patient with documented history of gum disease.<br>• Topical fluoride (D1206 or D1208) limited to one per calendar year.<br>• Intraoral complete series of radiographic images (D0210) – limited to one per three calendar years.<br>• Bitewing X-rays (D0270, D0272, D0273, D0274, D0277) – limited to one set per calendar year.<br>• Intraoral – periapical radiographic images (D0220, D0230).<br>• Panoramic radiographic image (D0330).<br>• Nutritional counseling (D1310) – limited to one per calendar year. | |
| **Comprehensive dental care†***<br><br>Comprehensive dental care is covered up to a **$1,000** annual benefit limit, when performed by participating LIBERTY Dental Plan providers and subject to the exclusions and limitations, including visit limits, described in Section 3.1 of this chapter. Visit Libertydentalplan.com/kaiserdentists for a listing of participating dentists or call Member Services at the LIBERTY Dental Plan at 1-888-650-1859 (TTY users call **711**), Monday through Friday, 8 a.m. to 8 p.m. Services performed by non-participating dentists are not covered. Covered services include:<br><br>**Minor restorative services:**<br>• Amalgam (D2140, D2150, D2160, D2161) and composite fillings (D2330, D2331, D2332, D2335, | You pay **50% coinsurance** for comprehensive dental care until the plan has paid **$1,000 (annual benefit limit).** When you reach the $1,000 annual benefit limit for comprehensive dental care, you pay 100% for the rest of the year.<br><br>**Note:** You have additional comprehensive dental coverage if you are enrolled in Advantage Plus Option 1 and/or Advantage Plus Option 2, our optional supplemental benefits packages. |

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

| Covered Service | What you pay |
|---|---|
| D2391, D2392, D2393, D2394) – limited to one per tooth per surface every two calendar years.<br>**Major restorative services:**<br>• Inlays (D2510, D2520, D2530, D2610, D2620, D2630) and onlays (D2542, D2543, D2544, D2642, D2643, D2644) – limited to one per tooth per 5 years.<br>• Crowns (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) – limited to one per tooth per 5 years.<br>• Re-cement or re-bond crown (D2920).<br>• Core buildup, including any pins when required (D2950) – limited to one per tooth per 5 years.<br>• Post and core in addition to crown, indirectly fabricated (D2952) and each additional indirectly fabricated post – same tooth (D2953) or prefabricated post and core in addition to crown (D2954) and each additional prefabricated post – same tooth (D2957) – limited to one per tooth per 5 years.<br>**Endodontics:**<br>• Pulp cap – direct/indirect (D3110).<br>• Endodontic therapy, anterior, premolar or molar tooth (D3310, D3320, D3330) – limited to one per tooth per lifetime.<br>• Retreatment of previous root canal therapy - anterior, premolar or molar tooth (D3346, D3347, D3348) – limited to one per tooth per lifetime.<br>**Periodontics:**<br>• Periodontal scaling and root planing (D4341, D4342) – limited to one per quadrant per two calendar years. Only 2 quadrants are payable on the same date of service. | Please see Section 2.1 in this chapter for details. |

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

| Covered Service | What you pay |
|---|---|
| • Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit (D4355) – limited to one every three calendar years.<br>**Prosthodontics, removable:**<br>• Complete or partial dentures- 1 of (D5110-D5226) per arch every 5 years.<br>• Complete denture – maxillary/mandibular (D5110, D5120).<br>• Immediate denture – maxillary/mandibular (D5130, D5140).<br>• Maxillary/mandibular partial denture - cast metal framework with resin denture bases (D5213, D5214).<br>• Immediate maxillary/mandibular partial denture – resin base (D5221, D5222).<br>• Maxillary/mandibular partial denture – flexible base (D5225, D5226).<br>• Adjust complete denture – maxillary/mandibular (D5410, D5411) – limited to two per denture per year.<br>• Adjust partial denture – maxillary/mandibular (D5421, D5422) – limited to two per denture per year.<br>• Repair broken complete denture base, maxillary/mandibular (D5511, D5512) – limited to one per denture per year.<br>• Replace missing or broken teeth – complete denture (each tooth) (D5520) – limited to one per denture per year.<br>• Repair resin partial denture base, mandibular/maxillary (D5611, D5612) – limited to one per denture per year. | |

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

| Covered Service | What you pay |
|---|---|
| • Repair cast partial framework, mandibular/maxillary (D5621, D5622) – limited to one per denture per year.<br>• Reline complete maxillary/mandibular denture (direct) (D5730, D5731) – limited to one per denture per year.<br>• Reline partial maxillary/mandibular denture (direct) (D5740, D5741) – limited to one per denture per year.<br>• Reline complete maxillary/mandibular denture (indirect) (D5750, D5751) – limited to one per denture per year.<br>• Reline maxillary/mandibular partial denture (indirect) (D5760, D5761) – limited to one per denture per year.<br>**Prosthodontics, fixed:**<br>• Pontics (D6210, D6211, D6212, D6240, D6241, D6242, D6245) – limited to one per tooth per 5 years.<br>• Pontics (D6214) – limited to one per tooth per 5 years.<br>• Retainer crowns (D6740, D6750, D6751, D6752, D6790, D6791, D6792) – limited to one per tooth per 5 years.<br>• Retainer crowns (D6794) – limited to one per tooth per 5 years.<br>• Re-cement or re-bond fixed partial denture (D6930).<br>**Oral & maxillofacial surgery:**<br>• Extraction, coronal remnants – primary tooth (D7111) – limited to one per tooth per lifetime.<br>• Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (D7140) – limited to one per tooth per lifetime. | |

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

| Covered Service | What you pay |
|---|---|
| • Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated (D7210) – limited to one per tooth per lifetime.<br>• Removal of residual tooth roots (cutting procedure) (D7250) – limited to one per tooth per lifetime.<br>• Incision and drainage of abscess – intraoral soft tissue (D7510, D7511).<br>**Adjunctive general services:**<br>• Palliative (emergency) treatment of dental pain – minor procedure (D9110), limit one per visit per year.<br>• Deep sedation/general anesthesia (D210, D9211, D9212, D9222, D9223, D9239, D9243, D9248).<br>• Inhalation of nitrous oxide/analgesia, anxiolysis (D9230). | |
| **Depression screening**<br>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals. | There is no coinsurance, copayment, or deductible for an annual depression screening visit. |
| **Diabetes screening**<br>We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. | There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. |

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

| Covered Service | What you pay |
|---|---|
| You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test. | |
| **Diabetes self-management training, diabetic services, and supplies**<br>For all people who have diabetes (insulin and non-insulin users). Covered services include:<br>• †Supplies to monitor your blood glucose: blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.<br>• Diabetes self-management training under certain conditions. | **$0** |
| • †Diabetic monitors (blood glucose and continuous glucose) | **$0** |
| • †For people with diabetes who have severe diabetic foot disease, one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes) including fitting. | **20% coinsurance** |
| **Durable medical equipment (DME) and related supplies†**<br>(For a definition of durable medical equipment, go to Chapter 10 and Chapter 3)<br>Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech | **20% coinsurance** except you pay **$0** for phototherapy equipment for home use.<br>**Oxygen equipment**<br>Your cost-sharing for Medicare oxygen equipment coverage is |

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

| Covered Service | What you pay |
|---|---|
| generating devices, oxygen equipment, nebulizers, and walkers.<br><br>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at kp.org/directory.<br><br>We also cover the following phototherapy equipment for home use that isn't covered by Medicare when medically necessary for the following conditions:<br>• Cutaneous T-cell lymphoma.<br>• Pityriasis lichenoides chronica.<br>• Recalcitrant prurigo and pruritis.<br>• Lichen planus.<br>• Severe widespread eczema that has failed topical treatments.<br>• Vitiligo in some circumstances. | **20% coinsurance,** every time you receive equipment.<br><br>Your cost-sharing won't change after you're enrolled for 36 months. |
| **Emergency care**<br><br>Emergency care refers to services that are:<br>• Furnished by a provider qualified to furnish emergency services<br>• Needed to evaluate or stabilize an emergency medical condition<br><br>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. | **$130** per Emergency Department visit<br><br>This copayment does not apply if you are immediately admitted directly to the hospital as an inpatient (it does apply if you are admitted to the hospital as an outpatient; for example, if you are admitted for observation).<br><br>†If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network |

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

| Covered Service | What you pay |
|---|---|
| Cost-sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network.<br><br>**You have worldwide emergency care coverage.** | hospital for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost-sharing you would pay at a network hospital. |
| **Fitness benefit (One Pass®)**<br><br>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:<br>• Gyms and Fitness Locations: You receive a membership with access to a wide variety of in-network gyms through the core and premium network. Fitness locations include national, local, and community fitness centers and boutique studios. You can use any in-network location, and you may use multiple participating fitness locations during the same month.<br>• Online Fitness: You have access to live, digital fitness classes and on-demand workouts through the One Pass member website or mobile app.<br>• Fitness and Social Activities: You also have access to groups, clubs, and social events through the One Pass member website.<br>• Home Fitness Kits: If you prefer to work out at home, you can also select one home fitness kit per calendar year for Strength, Yoga, or Dance. Kits are subject to change and once selected cannot be exchanged.<br><br>For more information about participating gyms and fitness locations, the program's benefits, or to set up your online account, please visit | **$0** |

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

| Covered Service | What you pay |
|---|---|
| http://www.YourOnePass.com or call 1-877-614-0618 (TTY 711), Monday through Friday, 9 a.m. to 10 p.m.<br><br>The following are not covered: Additional services (such as personal training, fee-based group fitness classes, expanded access hours, or additional classes outside of the standard membership offering).<br><br>One Pass® is a registered trademark of One Pass Solutions, 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. | |
| **Fitness benefit (memory)**<br><br>A subscription to online brain training system (called Brain HQ) to improve attention, brain speed, memory, people skills, navigation, and intelligence. | **$0** |
| **Health and wellness education programs**<br><br>These programs focus on healthy lifestyles such as weight management, bladder control, and falls prevention, and clinical conditions such as diabetes, cholesterol, and pain management. Programs are designed to enrich the wellbeing of members through classes that are available at Kaiser Permanente medical centers and online classes. Other self-guided programs and tools are available online and include recipes, information on a variety of health topics, a health encyclopedia, a drug encyclopedia, videos, digital coaching, health calculators which help | **$0** |

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

| Covered Service | What you pay |
|---|---|
| members check their progress to better health, walking, and weight control programs. Access to this information as well as online sign-up for classes available in your area can be found at kp.org/healthyliving after selecting your region. | |
| **Hearing services**<br>• †Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. | **$40** per visit |
| • †Hearing aids (prescriptions)<br>○ We provide a **$1,000 allowance** per hearing aid, per ear, that you can use toward the purchase of one hearing aid every 36 months. If two aids are required to provide significant improvement that is not obtainable with only one hearing aid, we will cover one hearing aid for each ear. The $1,000 allowance per ear may only be used once in any 36 month period.<br>○ Note: This hearing aid benefit is effective in the current contract year and may not be available next year. | If the hearing aid you purchase costs more than **$1,000, you pay the difference.**<br>**Note:** Your allowance is increased if you are enrolled in Advantage Plus Option 1 (see Section 2.1 in this chapter for details). |
| • †Evaluation and fitting for hearing aids.<br>• †Visits to verify that the hearing aid(s) conforms to the prescription.<br>• †Visits for counseling, adjustment, cleaning, and inspection after the warranty is exhausted. | **$0** |
| **HIV screening**<br>For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover:<br>• One screening exam every 12 months | There's no coinsurance, copayment, or deductible for |

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

| Covered Service | What you pay |
|---|---|
| If you are pregnant, we cover:<br>• Up to 3 screening exams during a pregnancy | members eligible for Medicare-covered preventive HIV screening. |
| **Home-based palliative care†**<br>Services not covered by Medicare in the home are provided in the form of palliative care to diminish symptoms of terminally ill members with a life expectancy of 7–12 months. Services include non-Medicare covered interdisciplinary palliative care support from physicians, nurses, and other clinicians providing services in the home. | **$0** |
| **Home health agency care†**<br>Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.<br>Covered services include, but aren't limited to:<br>• Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)<br>• Physical therapy, occupational therapy, and speech therapy<br>• Medical and social services<br>• Medical equipment and supplies | **$0**<br>**Note:** There is no cost-sharing for home health care services and items provided in accord with Medicare guidelines. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply if the item is covered under a different benefit; for example, durable medical equipment not provided by a home health agency. |
| **Home infusion therapy†**<br>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for | **$0** for professional services, training, and monitoring.<br>**Note:** The components (such as, Medicare Part B drugs, DME, and medical supplies) needed to |

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

| Covered Service | What you pay |
|---|---|
| example, a pump), and supplies (for example, tubing and catheters).<br><br>Covered services include, but aren't limited to:<br>• Professional services, including nursing services, furnished in accordance with our plan of care<br>• Patient training and education not otherwise covered under the durable medical equipment benefit<br>• Remote monitoring<br>• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier | perform home infusion may be subject to the applicable cost-sharing listed elsewhere in this Medical Benefits Chart depending on the item. |
| **Home medical care not covered by Medicare (Advanced Care at Home)†**<br>We cover medical care in your home that is not otherwise covered by Medicare when found medically appropriate by a physician based on your health status, to provide you with an alternative to receiving acute care in a hospital. Services in the home must be:<br>• Prescribed by a network hospitalist who has determined that based on your health status, treatment plan, and home setting that you can be treated safely and effectively in the home.<br>• Elected by you because you prefer to receive the care described in your treatment plan in your home.<br>We will provide the following services and items in your home in accord with your treatment plan for as long as they are prescribed by a network hospitalist:<br>• Home visits by RNs and other healthcare professionals in accord with the home care | **$0** |

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

| Covered Service | What you pay |
|---|---|
| treatment plan and the provider's scope of practice and license.<br>• The following equipment necessary to ensure that you are monitored appropriately in your home: blood pressure cuff/monitor, pulse oximeter, scale, and thermometer.<br>• Round-trip transportation from your home to a facility for prescribed services<br>• Up to 21 meals per week while you receive acute care in the home<br>• Mobile imaging and tests such as labs, EKGs, and ultrasounds. | |
| In addition, for Medicare-covered services and items listed below, the cost-sharing indicated elsewhere in this Medical Benefits Chart does not apply when the services and items are prescribed as part of your home treatment plan:<br>• Medical supplies.<br>• Physician assistant and nurse practitioner house calls or office visits.<br>• The following services at a network facility if the services are part of your home treatment plan:<br>o Emergency Department visits associated with this benefit.<br>o Outpatient observation visits associated with this benefit.<br>The cost-sharing indicated elsewhere in this Medical Benefits Chart will apply to all other services and items that aren't part of your home treatment plan (for example, medical supplies unrelated to your home treatment plan) or are part of your home treatment plan, but are not provided in your home except as listed above. **Note:** For prescription drug cost-sharing information, please refer to the | **$0** |

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

| Covered Service | What you pay |
|---|---|
| Medicare Part B prescription drug section in this chart. | |
| **Hospice care**<br>You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.<br>Covered services include:<br>• Drugs for symptom control and pain relief<br>• Short-term respite care<br>• Home care<br>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.<br>***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.<br>**For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services | When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan. |

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

| Covered Service | What you pay |
|---|---|
| covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization).<br>• If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services<br>• *If you get the covered services from an out-of-network provider, you pay the cost-sharing under Original Medicare<br>**For services covered by our plan but not covered by Medicare Part A or B:** We will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services.<br>**Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services. | |
| Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. | You pay the following, depending upon the type of visit:<br>• **$0** per primary care visit<br>• **$40** per specialty care visit† |
| **Immunizations**<br>Covered Medicare Part B services include:<br>• Pneumonia vaccines<br>• Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with | There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. |

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

| Covered Service | What you pay |
|---|---|
| additional flu/influenza shots (or vaccines) if medically necessary<br>• Hepatitis B vaccines if you've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you at high or intermediate risk of getting Hepatitis B<br>• COVID-19 vaccines<br>• Other vaccines if you're at risk and they meet Medicare Part B coverage rules | |
| **Inpatient hospital care†**<br>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.<br>There is no limit to the number of medically necessary hospital days or services that are generally and customarily provided by acute care general hospitals. Covered services include but aren't limited to:<br>• Semi-private room (or a private room if medically necessary)<br>• Meals including special diets<br>• Regular nursing services<br>• Costs of special care units (such as intensive care or coronary care units)<br>• Drugs and medications<br>• Lab tests<br>• X-rays and other radiology services<br>• Necessary surgical and medical supplies<br>• Use of appliances, such as wheelchairs | Cost-sharing is charged for each inpatient stay.<br>**$295 per day for days 1–6** of a hospital stay.<br>Thereafter you pay **$0** for the remainder of your covered hospital stay. Also, you do not pay the copayment listed above for the day you are discharged unless you are admitted and discharged on the same day.<br>†If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you'd pay at a network hospital. |

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

| Covered Service | What you pay |
|---|---|
| • Operating and recovery room costs<br>• Physical, occupational, and speech language therapy<br>• Inpatient substance abuse services<br>• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If we provide transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion, in accord with our travel and lodging guidelines, which are available from Member Services.<br>• Blood - including storage and administration<br>• Physician services<br>**Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff.<br>Get more information from the Medicare fact sheet Medicare Hospital Benefits available at | |

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

| Covered Service | What you pay |
|---|---|
| Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. | |
| **Inpatient services in a psychiatric hospital†**<br>Covered services include mental health care services that require a hospital stay.<br>• We cover up to 190 days per lifetime for inpatient stays in a Medicare-certified psychiatric hospital. The number of covered lifetime hospitalization days is reduced by the number of inpatient days for mental health treatment previously covered by Medicare in a psychiatric hospital.<br>• The 190-day limit doesn't apply to mental health stays in a psychiatric unit of a general hospital. | Cost-sharing is charged for each inpatient stay.<br>**$295 per day for days 1–6** of a covered hospital stay.<br>You pay **$0** per day for days 7–90 of a covered hospital stay. Also, you do not pay the copayment listed above for the day you are discharged unless you are admitted and discharged on the same day. |
| **Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay†**<br>If you've used up your inpatient mental health or skilled nursing facility (SNF) benefits or if the inpatient or SNF stay isn't reasonable and necessary, we won't cover your inpatient or SNF stay. In some cases, we'll cover certain services you get while you're in the hospital or SNF. Covered services include, but aren't limited to:<br>• Physician services<br>• Diagnostic tests (like lab tests)<br>• X-ray, radium, and isotope therapy including technician materials and services<br>• Surgical dressings<br>• Splints, casts, and other devices used to reduce fractures and dislocations | If your inpatient or SNF stay is no longer covered, we will continue to cover Medicare Part B services at the applicable cost-sharing listed elsewhere in this Medical Benefits Chart when provided by network providers. |

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

| Covered Service | What you pay |
|---|---|
| • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices<br>• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition<br>• Physical therapy, speech therapy, and occupational therapy | |
| **Medical nutrition therapy†**<br>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.<br>We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. | There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. |
| **Medicare Diabetes Prevention Program (MDPP)**<br>**MDPP services are covered for eligible people under all Medicare health plans.**<br>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and | There is no coinsurance, copayment, or deductible for the MDPP benefit. |

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

| Covered Service | What you pay |
|---|---|
| problem-solving strategies for overcoming challenges to sustain weight loss and a healthy lifestyle. | |
| **Medicare Part B drugs†**<br><br>**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:**<br>• 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<br>• Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)<br>• Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan<br>• The Alzheimer's drug, Leqembi® (generic name lecanemab) 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<br>• Clotting factors you give yourself by injection if you have hemophilia<br>• 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. | **Administered drugs**<br><br>You pay **$0** or **20% coinsurance** depending on the drug (please call Member Services to find out which drugs are provided at a coinsurance). Some drugs may be less than 20% if those drugs are determined to exceed the amount of inflation.<br><br>**All other Part B drugs**<br><br>For Medicare Part B prescription drugs on our formulary, you pay the following up to a 30-day supply, depending upon the type of pharmacy and drug:<br><br>Network pharmacy located at a Kaiser Permanente facility or our mail-order pharmacy:<br>• **$15** for generic drugs<br>• **$45** for brand-name drugs, except you pay **$35** for Part B insulin drugs furnished through an item of DME.<br><br>Network affiliated pharmacy that offers standard cost-sharing:<br>• **$20** for generic drugs<br>• **$47** for brand-name drugs, except you pay **$35** for Part B |

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

| Covered Service | What you pay |
|---|---|
| • 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<br>• 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<br>• 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.<br>• 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<br>• Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B<br>• Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar®<br>• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics<br>• 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) | insulin drugs furnished through an item of DME. |

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

| Covered Service | What you pay |
|---|---|
| • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases<br>• Parenteral and enteral nutrition (intravenous and tube feeding)<br>**Note:** We also cover some vaccines under our Part B drug benefit. | |
| **Nursing hotline**<br>We have a nursing hotline available for members to call for assistance. Our telephone 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.<br>They can often answer questions about a minor concern, tell you what to do if a network facility is closed, or advise you about what to do next, including making a same-day urgent care appointment for you if it's medically appropriate. To speak with an advice nurse 24 hours a day, 7 days a week or make an appointment, please call our Consulting Nurse Service Department at 1-800-777-7904 (TTY 711). | **$0** |
| **Obesity screening and therapy to promote sustained weight loss**<br>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more. | There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. |

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

| Covered Service | What you pay |
|---|---|
| **Opioid treatment program services†**<br>Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:<br>• U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications<br>• Dispensing and administration of MAT medications (if applicable) | You pay **$0** or **20% coinsurance** for clinically administered Medicare Part B drugs depending on the drug when provided by an Opioid Treatment Program. Some drugs may be less than 20% if those drugs are determined to exceed the amount of inflation. |
| • Substance use counseling<br>• Individual and group therapy<br>• Toxicology testing<br>• Intake activities<br>• Periodic assessments | **$40** per visit |
| **Outpatient diagnostic tests and therapeutic services and supplies†**<br>Covered services include, but aren't limited to:<br>• X-rays | **$10** |
| • Laboratory tests<br>• Electrocardiograms (EKGs), holter monitoring, and electroencephalograms (EEGs)<br>• Blood - including storage and administration | **$0** |
| • Radiation (radium and isotope) therapy, including technician materials and supplies | **$40** per visit |
| • Surgical supplies, such as dressings<br>• Splints, casts, and other devices used to reduce fractures and dislocations | **20% coinsurance** |
| • Other outpatient diagnostic tests: | **$150** per procedure |

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

| Covered Service | What you pay |
|---|---|
| ○ Magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET) | |
| ○ Ultrasounds | **$10** per procedure |
| • Other outpatient diagnostic tests:<br>○ Any diagnostic test or special procedure that is provided in an outpatient department of a hospital or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort | **$195** per visit |
| **Outpatient hospital observation†**<br>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.<br>For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.<br>**Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. | You pay **$195** per stay when admitted directly to the hospital for observation as an outpatient.<br>**Note:** There's no additional charge for outpatient observation stays when transferred for observation from an Emergency Department or following outpatient surgery. |

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

| Covered Service | What you pay |
|---|---|
| Get more information from the Medicare fact sheet Medicare Hospital Benefits available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. | |
| **Outpatient hospital services†**<br>We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.<br>Covered services include, but aren't limited to:<br>• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery | **Emergency Department**<br>**$130** per visit<br>**Outpatient Surgery**<br>**$195** per visit<br>Refer to the "Outpatient hospital observation" section of this Medical Benefits Chart for the cost-sharing applicable to observation services. |
| • Laboratory and diagnostic tests billed by the hospital | **$0** |
| • X-rays billed by the hospital | **$10** for per visit |
| • Other radiology services billed by the hospital | **MRI, CT, PET**<br>**$150** for per procedure |
| • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it | **$0** per day for partial hospitalization |
| • Medical supplies such as splints and casts | **20% coinsurance** for take home dressings and supplies. |
| • Certain drugs and biologicals you can't give yourself | **$0** or **20% coinsurance** depending on the drug (please call Member Services to find out which drugs |

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

| Covered Service | What you pay |
|---|---|
| | are provided at a coinsurance). Some drugs may be less than 20% if those drugs are determined to exceed the amount of inflation. |
| **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. | |
| **Outpatient mental health care†**<br>Covered services include:<br>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker (CSW), clinical nurse specialist (CNS), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. | You pay the following, depending upon the type of visit:<br>• **$20** per individual therapy visit<br>• **$10** per group therapy visit |
| **Outpatient rehabilitation services†**<br>Covered services include physical therapy, occupational therapy, and speech language therapy.<br>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). | **$35** per visit |
| **Outpatient substance use disorder services†**<br>Treatment for substance abuse is covered if medically necessary and reasonable for the patient's condition. | You pay the following, depending upon the type of visit:<br>• **$20** per individual therapy visit<br>• **$10** per group therapy visit |

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

| Covered Service | What you pay |
|---|---|
| **Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers†**<br><br>**Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.<br><br>Also, we cover non-emergency transesophageal echocardiography (TEE), electroconvulsive therapy (ECT), lap gastric sleeve, endoscopic sleeve gastroplasty, and inguinal node lymph biopsy procedures in an ASC if their health indicates that the procedure can be performed safely and effectively in that setting during regular ASC operating hours. | **$195** per visit |
| **Over-the-Counter (OTC) items***<br><br>You will receive a preloaded healthy extras card with the quarterly allowance listed on the right to purchase eligible OTC items both online and at participating retail stores, including at Kaiser Permanente retail pharmacies. The list of eligible items is subject to change. Your card will be reloaded on January 1, April 1, July 1, and October 1.<br><br>Any unused portion of the quarterly allowance will not roll over to the next quarter.<br><br>The cost of eligible OTC items will be covered up to the balance available on your card. If there is a remaining amount to pay, you must use another form of payment. You can't use your healthy extras card for tips or any fees for service, delivery, shipping, or vehicle-loading. Fees and minimum order requirements vary by retailers. Please review details | You pay **$0** up to the **$25** quarterly allowance. |

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

| Covered Service | What you pay |
|---|---|
| about fees on the checkout page prior to placing an online order. You will be prompted to enter another form of payment for any tips, fees, or non-covered items.<br><br>**How to use your healthy extras card**<br><br>To activate your healthy extras card, call 1-833-524-7035 (TTY 711), 7 days a week, 8 a.m. to 8 p.m. EST, and provide your card number and membership ID number. Once you activate your card, you may start using your card to access your allowance to purchase approved items at participating retail and online stores.<br><br>If you already have a healthy extras card, you will not receive a new card. Please keep your card and your benefit will be available on your existing card.<br><br>To set up your online account, request a catalog, view a list of eligible OTC items, find participating stores, check your balance and transaction history, shop online, submit a request for reimbursement, or replace a lost or stolen card, please visit mybenefitscenter.com or call 1-833-524-7035 (TTY 711), 7 days a week, 8 a.m. to 8 p.m. EST.<br><br>If your card is declined or does not process correctly, you may complete the transaction with another form of payment and submit a reimbursement request, which will require a copy of your itemized receipt. Reimbursement requests are subject to a determination process and must be submitted to us within 90 days from the date of purchase on your proof of payment or receipt.<br><br>You may also visit mybenefitscenter.com and download the OTC Network mobile app to find participating retailers, search for eligible items, review your transaction history and check your card balance. You can also use the OTC mobile app at | |

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

| Covered Service | What you pay |
|---|---|
| stores to scan items for eligibility during shopping and view your balance before you check out. Members can download the OTC Network mobile app directly from the iTunes App Store or GooglePlay. Search "OTC Network" to download.<br><br>**Note:** Any unused amounts are forfeited upon disenrollment from our plan. | |
| **Partial hospitalization services and intensive outpatient services†**<br><br>*Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.<br><br>**Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service. | **$0** per day |
| *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally Qualified Health Center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization. | **$0** per day |
| **Physician/practitioner services, including doctor's office visits**<br><br>Covered services include: | **Office visits** |

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

| Covered Service | What you pay |
|---|---|
| • †Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location<br>• †Consultation, diagnosis, and treatment by a specialist<br>• †Basic hearing and balance exams performed by your network provider, if your doctor orders it to see if you need medical treatment<br>• Second opinion by another network provider prior to surgery | **$0** per visit with a primary care provider (such as such as family medicine, internal medicine, allergy injection visits, or visits with clinical pharmacists).<br>**$40** per visit with a specialist (such as gynecology, cardiology, orthopedics, gastroenterology, neurology, allergy testing and evaluation, and pain management injections).<br>**Outpatient surgery**<br>**$195** per visit |
| • Certain telehealth services, including: primary and specialty care, which includes cardiac rehabilitation, urgently needed services, physical, speech, and occupational therapies, mental health care, podiatry, psychiatry services, diagnostic procedures and tests, substance abuse treatment, dialysis services, kidney disease education, and diabetes self-management training, preparation for surgery or a hospital stay, and follow up visits after a hospital stay, surgery, or Emergency Department visit. Services will only be provided by telehealth when deemed clinically appropriate by the network provider rendering the service<br>• You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. We offer the following means of telehealth: | **$0** |

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

| Covered Service | What you pay |
|---|---|
| ○ Interactive video visits for professional services when care can be provided in this format as determined by a network provider<br>○ Scheduled telephone appointment visits for professional services when care can be provided in this format as determined by a network provider<br>• 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<br>• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location<br>• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location<br>• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders<br>• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers<br>• Virtual check-ins (for example, by phone or video chat) with your doctor for 5–10 minutes **if**:<br>○ You're not a new patient **and**<br>○ The check-in isn't related to an office visit in the past 7 days **and**<br>○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment<br>• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:<br>○ You're not a new patient **and** | |

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

| Covered Service | What you pay |
|---|---|
| ○ The evaluation isn't related to an office visit in the past 7 days **and**<br>○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment<br>• Consultation your doctor has with other doctors by phone, internet, or electronic health record | |
| **Podiatry services†**<br>Covered services include:<br>• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)<br>• Routine foot care for members with certain medical conditions affecting the lower limbs | **Office visits**<br>**$40** per visit<br>**Outpatient surgery**<br>**$195** per visit |
| **Pre-exposure prophylaxis (PrEP) for HIV prevention**<br>If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services.<br>If you qualify, covered services include:<br>• FDA-approved oral or injectable PrEP medication including the fee for injecting the drug, if applicable<br>• Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months<br>• Up to 8 HIV screenings every 12 months<br>• A one-time hepatitis B virus screening | There is no coinsurance, copayment, or deductible for the PrEP benefit. |

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

| Covered Service | What you pay |
|---|---|
| **Prostate cancer screening exams**<br>For men aged 50 and older, covered services include the following once every 12 months:<br>• Digital rectal exam<br>• Prostate Specific Antigen (PSA) test | There is no coinsurance, copayment, or deductible for an annual digital rectal exam or PSA test. |
| **Prosthetic and orthotic devices and related supplies†**<br>Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this table for more detail. | **20% coinsurance** for external prosthetic or orthotic devices and supplies (including wound care supplies).<br>**$0** for surgically implanted internal devices. |
| We also cover these items not covered by Medicare:<br>• Therapeutic shoes not covered by Medicare to treat peripheral vascular conditions and neuropathy affecting the legs and feet. | **20% coinsurance** |
| **Pulmonary rehabilitation services†**<br>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. | **$35** per visit |

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

| Covered Service | What you pay |
|---|---|
| **Screening and counseling to reduce alcohol misuse**<br>We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent.<br>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting. | There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. |
| **Screening for lung cancer with low dose computed tomography (LDCT)**<br>For qualified people, an LDCT is covered every 12 months.<br>**Eligible members are** people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.<br>*For LDCT lung cancer screenings after the initial LDCT screening:* the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits. | There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT. |

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

| Covered Service | What you pay |
|---|---|
| **Screening for Hepatitis C virus infection**<br>We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions:<br>• You're at high risk because you use or have used illicit injection drugs.<br>• You had a blood transfusion before 1992.<br>• You were born between 1945-1965.<br>If you were born between 1945-1965 and aren't considered high risk, we cover a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings. | There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus. |
| **Screening for sexually transmitted infections (STIs) and counseling to prevent STIs**<br>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.<br>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office. | There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. |

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

| Covered Service | What you pay |
|---|---|
| **Services to treat kidney disease†**<br>Kidney disease and dialysis services include:<br>• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime<br>• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) | **$0** |
| • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible)<br>• Home dialysis equipment and supplies<br>• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) | **20% coinsurance** |
| • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care). | No additional charge for services received during a hospital stay. Refer to the "Inpatient hospital care" section of this Medical Benefits Chart for the cost-sharing applicable to inpatient stays. |
| Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table. | |

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

| Covered Service | What you pay |
|---|---|
| **Skilled nursing facility (SNF) care†**<br><br>(For a definition of skilled nursing facility care, go to Chapter 10. Skilled nursing facilities are sometimes called SNFs.)<br><br>We cover up to 100 days per benefit period of skilled inpatient services in a skilled nursing facility in accord with Medicare guidelines (a prior hospital stay is not required). Covered services include but aren't limited to:<br>• Semiprivate room (or a private room if medically necessary)<br>• Meals, including special diets<br>• Skilled nursing services<br>• Physical therapy, occupational therapy and speech therapy<br>• Drugs administered to you as part of our plan of care (this includes substances naturally present in the body, such as blood clotting factors.)<br>• Blood - including storage and administration.<br>• Medical and surgical supplies ordinarily provided by SNFs<br>• Laboratory tests ordinarily provided by SNFs<br>• X-rays and other radiology services ordinarily provided by SNFs<br>• Use of appliances such as wheelchairs ordinarily provided by SNFs<br>• Physician/Practitioner services<br><br>Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. | Per benefit period, you pay **$0** per day for days 1–20 and **$221** per day for days 21–100.<br><br>A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or skilled nursing facility (SNF). The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 calendar days in a row.<br><br>**Note:** If a benefit period begins in 2026 for you and does not end until sometime in 2027, the 2026 cost-sharing will continue until the benefit period ends. |

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

| Covered Service | What you pay |
|---|---|
| • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care)<br>• A SNF where your spouse or domestic partner is living at the time you leave the hospital | |
| **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)**<br>Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria:<br>• Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease<br>• Are competent and alert during counseling<br>• A qualified physician or other Medicare-recognized practitioner provides counseling<br>We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.) | There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. |
| **Supervised exercise therapy (SET)†**<br>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.<br>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.<br>The SET program must:<br>• Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication | **$25** per visit |

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

| Covered Service | What you pay |
|---|---|
| • Be conducted in a hospital outpatient setting or a physician's office<br>• Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD<br>• Be under the direct supervision of a physician, physician assistant (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) who must be trained in both basic and advanced life support techniques<br>SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. | |
| **Transportation benefit – Non-Emergency Medical Transportation not covered by Medicare — Routine***<br>We cover up to 24 one-way trips per calendar year to take you to and from a network provider when provided by our designated transportation provider.<br>To schedule a ride or find out how many rides you have left for the year (ride balance), please call 1-855-932-5412 (TTY 711), 24 hours a day, 7 days a week. You can also schedule rides online at kpmas.member.saferidehealth.com. Rides must be scheduled at least 2 hours before your pick-up time. You must cancel rides at least 3 hours before the scheduled pick-up time. If not, the ride will be deducted from your annual ride balance. | You pay **$0** for 24 one-way trips. |
| **Transportation services – Non-Emergency Medical Transportation not covered by Medicare - Non-routine***<br>When ordered by a network provider, we cover medically necessary non-emergency medical | **$0** |

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

| Covered Service | What you pay |
|---|---|
| transportation in a licensed stretcher/gurney van or wheelchair van to home (must be within 100 miles), a skilled nursing facility, or a transfer to another higher level of care immediately following:<br>• an inpatient hospitalization, or<br>• certain emergency, urgent care, or outpatient hospital encounters | |
| **Urgently needed services**<br>A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost-sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.<br>• **Inside our service area:** You must obtain urgent care from network providers, unless our provider network is temporarily unavailable or inaccessible due to an unusual and extraordinary circumstance (for example, major disaster).<br>• **Outside our service area:** You have worldwide urgent care coverage when you travel if you need medical attention right away for an unforeseen illness or injury and you reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our service area. | **Office visits**<br>**$40** per visit<br>**Emergency Department visits**<br>**$130** per Emergency Department visit |

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

| Covered Service | What you pay |
|---|---|
| **See Chapter 3, Section 3, for more information.** | |
| **Vision care**<br>Covered services include:<br>• †Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration (prior authorization only applies to services from an ophthalmologist).<br>• †Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. However, our plan does cover the following exams:<br>  ○ Routine eye exams (eye refraction exams) to determine the need for vision correction and to provide a prescription for eyeglass lenses (prior authorization only applies to services from an ophthalmologist). | You pay the following, depending upon the type of visit:<br>• **$0** per optometrist visit<br>• **$40** per ophthalmologist visit |
| • For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older.<br>• †For people with diabetes, screening for and monitoring of diabetic retinopathy. | **$0** |
| • †One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery.<br>• †Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. | **20% coinsurance**<br>***Note:** If the eyewear you purchase costs more than what Medicare covers, you pay the difference. |

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

| Covered Service | What you pay |
|---|---|
| • †**Other eyewear:** Once every year, we provide a **$200** allowance for you to use toward the purchase price of eyewear from a network optical facility when a network physician or optometrist prescribes an eyeglass or contact lens for vision correction.<br>• The allowance can be used once every year for the following items:<br>  ○ Eyeglass lenses when a network provider puts the lenses into a frame.<br>  ○ Eyeglass frames for refractive purposes.<br>  ○ Eyeglass frames when a network provider puts two lenses (at least one of which must have refractive value) into the frame.<br>  ○ Contact lenses, fitting, and dispensing.<br>• 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.<br>**Note:** This allowance cannot be used for eyewear obtained following cataract surgery. | *If the eyewear you purchase costs more than **$200, you pay the difference.**<br>**Note:** Your allowance is increased if you are enrolled in Advantage Plus Option 1 (see Section 2.1 in this chapter for details). |
| **Welcome to Medicare preventive visit**<br>Our plan covers the one-time Welcome to Medicare preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (and vaccines)), and referrals for other care if needed.<br>**Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit. | There is no coinsurance, copayment, or deductible for the Welcome to Medicare preventive visit. |

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

| Covered Service | What you pay |
|---|---|
| **Note:** Refer to Chapter 1 Section 7, and Chapter 9 for information about coordination of benefits that applies to all covered services described in this Medical Benefits Chart. | |

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

## Section 2.1 Extra optional supplemental benefits you can buy

Our plan offers some extra benefits that aren't covered by Original Medicare and not included in your benefits package. These extra benefits are called **Optional Supplemental Benefits**. If you want these optional supplemental benefits, you must sign up for them and you may have to pay an additional premium for them. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits.

We offer two optional supplemental benefits packages called "Advantage Plus." You only receive the benefits described in this section if you are enrolled in one or both of the Advantage Plus options. When you enroll in Advantage Plus Option 1, you are purchasing all the supplemental benefits associated with that option. You cannot purchase just one benefit within Advantage Plus Option 1; for example, hearing aid coverage only.

- Option 1 includes comprehensive dental, hearing aid, and eyewear benefits.
- Option 2 includes comprehensive dental benefits.

### When you can enroll in Advantage Plus

You can enroll in Advantage Plus by selecting it when you complete your Kaiser Permanente Medicare Advantage Liberty enrollment form. If you didn't select Advantage Plus when you enrolled in Kaiser Permanente Medicare Advantage Liberty, you can enroll in Advantage Plus during one of the following times by sending us a completed Advantage Plus enrollment form:

- Between October 15 and December 31, for coverage to become effective on January 1.
- Between January 1 and March 31 or within 30 days of enrolling in Kaiser Permanente Medicare Advantage Liberty. Coverage is effective the first of the month following the date we receive your completed Advantage Plus enrollment form.

### Disenrollment from Advantage Plus

You can terminate your Advantage Plus coverage at any time. Your disenrollment will be effective the first of the month following the date we receive your completed form. Any overpayment of premiums will be refunded. Call Member Services to request a disenrollment form.

If you disenroll from Advantage Plus and want to join in the future, please see "When you can enroll in Advantage Plus" above for the times when you can enroll. Please keep in mind that your hearing aid and eyewear benefits will not renew upon reenrollment because hearing aids are provided once every 36 months and eyewear is provided once every year.

| **Advantage Plus Option 1**<br>**(These optional supplemental benefits only apply to members enrolled in Advantage Plus)** | **What you must pay*** |
|---|---|
| **Additional monthly premium**<br>This additional monthly premium is added to your Kaiser Permanente Medicare Advantage Liberty plan premium (see Chapter 1, Section 4.3, for more premium information). | **$18** |
| **Additional eyewear coverage†**<br>• Enrollment in Advantage Plus increases your standard eyewear allowance described in the Medical Benefits Chart under "Vision care" by adding an additional **$275** allowance to your standard allowance.<br>• You may use this allowance toward the purchase price of eyewear once every year. If you do not use all of the combined allowance at the initial point of sale, you cannot use it later.<br>• Eyewear must be purchased at a network optical facility.<br>**Note:** This allowance does not apply to eyewear obtained following cataract surgery. | If the eyewear you purchase costs more than **your allowance, you pay the difference.** |
| **Additional hearing aid coverage†**<br>• Enrollment in Advantage Plus increases your standard hearing aid allowance described in the Medical Benefits Chart under "Hearing services" by adding an additional **$1,000** allowance to your standard allowance.<br>• You may use this allowance toward the purchase of one hearing aid every 36 months. If two aids are required to provide significant improvement that is not obtainable with only one hearing aid, we will cover one hearing aid for each ear. The combined allowance per ear may only be used once in any 36 month period. If you do not use all of the combined allowance at the initial point of sale, you cannot use it later.<br>• We select the provider or vendor that will furnish the covered hearing aid. Coverage is limited to the types and models of hearing aids furnished by the provider or vendor.<br>• **Note:** This hearing aid benefit is effective in the current contract year and may not be available next year. | If the hearing aid you purchase costs more than the allowance, **you pay the difference.** |

| **Advantage Plus Option 1 (These optional supplemental benefits only apply to members enrolled in Advantage Plus)** | **What you must pay*** |
|---|---|
| • Evaluation and fitting for hearing aids.<br>• Visits to verify that the hearing aid(s) conforms to the prescription.<br>• Visits for counseling, adjustment, cleaning, and inspection after the warranty is exhausted. | **$0** |
| **Comprehensive dental services†**<br>Enrollment in Advantage Plus Option 1 increases your in-network annual benefit limit for comprehensive dental services as described in the Medical Benefits Chart under "Dental services" by adding an additional **$500** to the standard in-network annual benefit limit.<br>Dental benefits are provided by LIBERTY Dental. To find an in-network dentist, call 1-888-650-1859 or visit Libertydentalplan.com/kaiserdentists.<br>**Note:** For information about the preventive dental benefits included in your health plan, please also refer to the "Dental services" row in the Medical Benefits Chart above. | **50% coinsurance** for comprehensive dental care until the plan has paid **$500 (annual benefit limit).** When you reach the $500 annual benefit limit for comprehensive dental care, you pay 100% for the rest of the year.<br>This annual benefit limit is added to your plan's base dental benefit. |

| **Advantage Plus Option 2 (These optional supplemental benefits only apply to members enrolled in Advantage Plus)** | **What you must pay*** |
|---|---|
| **Additional monthly premium**<br>This additional monthly premium is added to your Kaiser Permanente Medicare Advantage Liberty plan premium (see Chapter 1, Section 4.3, for more premium information). | **$23** |

| Advantage Plus Option 2<br>(These optional supplemental benefits only apply to members enrolled in Advantage Plus) | What you must pay* |
|---|---|
| **Comprehensive dental services†**<br>Enrollment in Advantage Plus Option 2 increases your in-network annual benefit limit for comprehensive dental services as described in the Medical Benefits Chart under "Dental services" by adding an additional **$1,000** to the standard in-network annual benefit limit.<br>Dental benefits are provided by LIBERTY Dental. To find an in-network dentist, call 1-888-650-1859 or visit Libertydentalplan.com/kaiserdentists.<br>**Note:** For information about the preventive dental benefits included in your health plan, please also refer to the "Dental services" row in the Medical Benefits Chart above. | **50% coinsurance** for comprehensive dental care until the plan has paid **$1,000 (annual benefit limit)**. When you reach the $1,000 annual benefit limit for comprehensive dental care, you pay 100% for the rest of the year.<br>This annual benefit limit is added to your plan's base dental benefit. |

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

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

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

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

| Services not covered by Medicare | Covered only under specific conditions |
|---|---|
| **Acupuncture** | Available for people with chronic low back pain under certain circumstances |

| Services not covered by Medicare | Covered only under specific conditions |
|---|---|
| **Care in an intermediate or residential care facility, assisted living facility, or adult foster home** | Not covered under any condition |
| **Conception by artificial means, such as in vitro fertilization, zygote intrafallopian transfers, ovum transplants, and gamete intrafallopian transfers (except artificial insemination and related services covered by Medicare)** | Not covered under any condition |
| **Cosmetic surgery or procedures** | Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member<br>Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance |
| **Custodial care**<br>Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing | Not covered under any condition |
| **Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance)** | Covered if medically necessary and covered under Original Medicare. |
| **Experimental medical and surgical procedures, equipment, and medications** | May be covered by Original Medicare under a Medicare-approved clinical research study. |

| Services not covered by Medicare | Covered only under specific conditions |
|---|---|
| Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community | (Go to Chapter 3, Section 5 for more information on clinical research studies) |
| **The following eyewear services and items:**<br>• Lens protection plan.<br>• Nonprescription products.<br>• Industrial or safety lenses and frames.<br>• Lenses and sunglasses without refractive value, except that this exclusion doesn't apply to a clear balance lens if only one eye needs correction or tinted lenses when medically necessary to treat macular degeneration or retinitis pigmentosa.<br>• Replacement of lost, broken, or damaged lenses or frames.<br>• Eyeglass or contact lens adornment.<br>• Eyewear items that do not require a prescription by law (other than eyeglass frames or a covered balance lens). | Not covered under any condition<br>**Note**: One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens. See "Vision care" in the Medical Benefits Chart for more information. |
| **Fees charged for care by your immediate relatives or members of your household** | Not covered under any condition |
| **Full-time nursing care in your home** | Not covered under any condition |
| **Home-delivered meals** | Not covered under any condition |

| Services not covered by Medicare | Covered only under specific conditions |
|---|---|
| **Homemaker services include basic household help, including light housekeeping or light meal preparation.** | Not covered under any condition |
| **Licensed ambulance services without transport** | Covered if the ambulance transports you or if covered by Medicare. |
| **Massage therapy** | Covered when ordered as part of physical therapy program in accord with Medicare guidelines. |
| **Naturopath services (uses natural or alternative treatments)** | Not covered under any condition |
| **Nonconventional intraocular lenses (IOLs) following cataract surgery (for example, a presbyopia-correcting IOL)** | Not covered under any condition |
| **Orthopedic shoes or supportive devices for the feet** | Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease |
| **Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television** | Not covered under any condition |
| **Physical exams and other services**<br>(1) required for obtaining or maintaining employment or participation in employee programs,<br>(2) required for insurance or licensing, or<br>(3) on court order or required for parole or probation | Covered if a network physician determines that the services are medically necessary or medically appropriate preventive care. |
| **Private duty nursing** | Not covered under any condition |
| **Private room in a hospital** | Covered only when medically necessary. |

| Services not covered by Medicare | Covered only under specific conditions |
|---|---|
| **Psychological testing for ability, aptitude, intelligence, or interest** | Not covered under any condition |
| **Radial keratotomy, LASIK surgery, and other low-vision aids** | Not covered under any condition |
| **Reconstructive surgery that offers only a minimal improvement in appearance or is performed to alter or reshape normal structures of the body in order to improve appearance** | We cover reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defect, developmental abnormalities, accidental injury, trauma, infection, tumors, or disease, if a network physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible. |
| **Reversal of sterilization procedures and non-prescription contraceptive supplies** | Not covered under any condition |
| **Routine chiropractic care** | Manual manipulation of the spine to correct a subluxation is covered |
| **Routine foot care** | Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes) |
| **Routine hearing exams, hearing aids, or exams to fit hearing aids** | Medicare covers diagnostic hearing exams and balance exams if ordered by a physician. |
| **Services considered not reasonable and necessary, according to Original Medicare standards** | This exclusion doesn't apply to services or items that aren't covered by Original Medicare but are covered by our plan. |
| **Services provided to veterans in Veterans Affairs (VA) facilities** | When emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our plan's cost-sharing amounts. |
| **Services related to noncovered services or items** | When a service or item is not covered, all services related to the noncovered service or item are excluded,<br>(1) except for services or items we would otherwise cover to treat complications of the noncovered service or item, or |

| Services not covered by Medicare | Covered only under specific conditions |
|---|---|
| | (2) unless covered in accord with Medicare guidelines. |
| **Services to reverse voluntary, surgically induced infertility** | Not covered under any condition |
| **Travel and lodging expenses** | We may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines. |

## Section 3.1 Dental limitations and exclusions

**Dental general terms and conditions**
Subject to the terms, conditions, limitations, and exclusions specified in this *Evidence of Coverage* including Section 3.1 of this chapter and Chapter 12, you may receive covered dental services from participating dental providers.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. has entered into an agreement with LIBERTY Dental Plan to provide covered dental services through participating dental providers.

Please note that some services require clinical review for pre-authorization approval prior to treatment. Certain documentation must be submitted with these pre-authorization requests. These services are clinically reviewed using the provided documentation to determine if they are indicated and appropriate based on industry standards, and that they meet all requirements specific to such service as outlined in LIBERTY's clinical criteria and guidelines. Any treatment which, in the opinion of LIBERTY's dental director, is not necessary or does not meet our plan's criteria will not be covered. If the required documentation is not provided, the service cannot be adequately reviewed and will therefore be denied. If the prior authorization is denied for any reason, the service will not be covered, and you will be responsible for all associated costs.

Coverage is limited to the services listed in the Medical Benefit Chart. If a service is not listed, it is not included and is not covered. To locate a network provider or to review LIBERTY Dental Plan's clinical guidelines, you may call LIBERTY's Member Services at 1-888-650-1859 or search the LIBERTY Dental online provider directory at Libertydentalplan.com/kaiserdentists. It is recommended that you work with your in-network dentist to check benefit coverage prior to obtaining dental services. If you choose to use a provider outside of the network, the services you receive will not be covered.

Additional limitations and exclusions are listed below:

- You may obtain a list of participating dental providers by visiting or for assistance concerning dental coverage questions, or for help finding a participating dental provider Libertydentalplan.com/kaiserdentists. or by contacting LIBERTY Dental Plan

at the numbers listed below or Kaiser Permanente's Member Services Department at 1-888-777-5536 (TTY 711) 7 days a week, 8 a.m. to 8 p.m.

- LIBERTY's Integrated Voice Response System is available 24 hours a day for information about participating dental providers in your area, or to help you select a participating dental provider. The most up-to-date list of participating dental providers can be found at the following website: Libertydentalplan.com/kaiserdentists.

LIBERTY also provides many other secure features online at Libertydentalplan.com.

**Exclusions**

Some services are clinically reviewed to determine if the services are necessary and appropriate based upon industry standards and LIBERTY clinical guidelines. Below are some of LIBERTY's clinical criteria and guidelines. Access to a complete and comprehensive list of LIBERTY's clinical criteria and guidelines is available through Member Services at 1-888-650-1859 or search the LIBERTY Dental member site at Libertydentalplan.com/kaiserdentists. Services requested without the required documentation provided will be denied.

- Requests for crowns, root canals and partial dentures require the tooth/teeth to have a good long-term restorative, endodontic, and periodontal (at least 50% bone support) prognosis for approval.
- Requests for crowns on teeth without root canal treatment must show evidence of decay, fracture, failing restoration, etc., undermining more than 50% of the tooth.
- Replacement of an existing crown, partial or denture which, in the opinion of LIBERTY's Dental Director, is satisfactory or that can be made satisfactory is not covered.
- Cosmetic or experimental dental services, and/or procedures not generally performed in a general dentist office.
    - Crowns for the purposes of esthetics, or as a result of normal wear & attrition, recession, abfraction and/or abrasion are not covered.
- Any procedure not specifically listed as a covered benefit in the Medical Benefits Chart or Advantage Plus sections above.
    - Any requested services that are in conjunction or reliant upon the completion of a denied service will also be denied.
- Any treatment covered under an individual or group medical plan, auto insurance, no fault auto insurance or uninsured motorist policy, to the extent permitted by federal or state statute, is not covered.

- Treatment as a result of civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime, is not covered.
- Services for injuries and/or conditions which are paid or payable under Worker's Compensation or Employer Liability Laws, and treatment provided without cost to you by any municipality, county, or other political subdivision is not covered.
- Fees related to broken appointments, preparing or copying dental reports, duplication of X-rays, itemized bills or claim forms are not covered.
- Cost of hospitalization and/or pharmaceuticals.
- Any services performed by a non-network general dentist or non-network specialist.
- Services that cannot be performed because of the general health of the patient.
- Services which are not consistent with the usual and customary services provided by a network general dentist or specialist.
- Any dental treatment started prior to the member's effective date.
- Treatment related to cysts, neoplasms and/or malignancies.
- Services which, in the opinion of the network general dentist or specialist, are not necessary for the patient's dental health.

# CHAPTER 5:
# Asking us to pay our share of a bill for covered medical services

## SECTION 1 Situations when you should ask us to pay our share for covered services

Sometimes when you get medical care, 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 covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

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

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

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

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

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

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

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

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

**3. If you're retroactively enrolled in our plan**

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

If you were retroactively enrolled in our plan and you paid out-of-pocket for any covered services 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 send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

## SECTION 2 How to ask us to pay you back or pay a bill you got

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you've made. It's a good idea to

make a copy of your bill and receipts for your records. You must submit your claim to us within 12 months of the date you got the service or item.

To make sure you're giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- You can file a claim to request payment by completing and submitting our electronic form at kp.org and upload supporting documentation.
- Download a copy of the form from our website (kp.org) or call Member Services at 1-888-777-5536 (TTY users call 711) and ask them to send you the form. Mail the completed form to our Claims Department address listed below.
- If you are unable to get the form, you can file your request for payment by sending us the following information to our Claims Department address listed below.
    - A statement with the following information:
        - Your name (member/patient name) and medical/health record number.
        - The date you received the services.
        - Where you received the services.
        - Who provided the services.
        - Why you think we should pay for the services.
        - Your signature and date signed. (If you want someone other than yourself to make the request, we will also need a completed "Appointment of Representative" form, which is available at kp.org.)
        - A copy of the bill, your medical record(s) for these services, and your receipt if you paid for the services.

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

Kaiser Permanente
Claims Department
Mid-Atlantic States Region
P.O. Box 371860
Denver, CO 80237-9998

## SECTION 3 We'll consider your request for payment and say yes or no

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

- If we decide the medical care is covered and you followed all the rules, we'll pay for our share of the cost. If you already paid for the service, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service yet, we'll mail the payment directly to the provider.
- If we decide the medical care 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 rights to appeal that decision.

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

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7.

# CHAPTER 6:
# Your rights and responsibilities

## SECTION 1 Our plan must honor your rights and cultural sensitivities

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

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan may meet these accessibility requirements include, but 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. This document is available in Spanish by calling Member Services. We can also give you information in large font, braille, audio file, or data file 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 1-888-777-5536 (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 get this service at in-network cost-sharing.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Member Services at 1-888-777-5536 (TTY users call 711). You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

### Sección 1.1 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, archivo de audio o en archivo 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 archivo 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 1-888-777-5536 (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 1-800-443-0815/1-888-777-5536 (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.

### Section 1.2 We must ensure you get timely access to covered services

You have the right to choose a primary care provider (PCP) in our plan’s network to provide and arrange for your covered services. You also have the right to go to a women’s health

specialist (such as a gynecologist) without a referral, as well as other providers described in Chapter 3, Section 2.2.

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

If you think you aren't getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

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

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

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

**How do we protect the privacy of your health information?**

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you've 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. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

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

If you have questions or concerns about the privacy of your personal health information, call Member Services at 1-888-777-5536 (TTY users call 711).

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

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

If you want any of the following kinds of information, call Member Services at 1-888-777-5536 (TTY users call 711):

- **Information about our plan**. This includes, for example, information about our plan's financial condition.
- **Information about our network providers.** You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service isn't covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

## Section 1.5 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.
- **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. If you refuse treatment, you accept full responsibility for what happens to your body as a result.

**You have the right to give instructions about what'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 in these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

**How to set up an advance directive to give instructions:**

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Member Services at 1-888-777-5536 (TTY users call 711) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

**If your instructions aren't followed**

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with

| District of Columbia Residents | Maryland Residents | Virginia Residents |
|---|---|---|
| District of Columbia Department of Insurance, Securities and Banking<br>810 First St., NE, Suite 701<br>Washington, DC 20002 | Maryland Insurance Administration<br>Consumer Complaint Investigation<br>200 St. Paul Place, Suite 2700<br>Baltimore, MD 21202 | State Corporation Commission<br>Virginia Bureau of Insurance<br>P.O. Box 1157<br>Richmond, VA 23218 |

## Section 1.6 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, Chapter 7 of this document tells what you can do. Whatever you do — ask for a coverage decision, make an appeal, or make a complaint — **we're required to treat you fairly.**

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

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

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

- **Call Member Services at 1-888-777-5536 (TTY users call 711)**
- **Call your local SHIP** at 1-202-671-4815
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

### Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services at 1-888-777-5536 (TTY users call 711)**
- **Call your local SHIP** at Maryland Department of Aging: 1-410-767-1100 or toll free 1-800-243-3425 (TTY 711), District of Columbia Department of Aging and Community Living: 1-202-724-5626 (TTY 711), or Virginia Insurance Counseling and Assistance Program: 1-804-662-9333 or toll free 1-800-552-3402 (TTY 711)
- **Contact Medicare**
    - Visit Medicare.gov to read the publication *Medicare Rights & Protections.* (available at: Medicare Rights & Protections)
    - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

### Section 1.9 Information about new technology assessments

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

### Section 1.10 You can make suggestions about rights and responsibilities

As a member of our plan, you have the right to make recommendations about the rights and responsibilities included in this chapter. Please call Member Services at 1-888-901-4600 (TTY users call 711) with any suggestions.

## SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Member Services at 1-888-777-5536 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* document to learn what's covered and the rules you need to follow to get covered services.
    - Chapters 3 and 4 give details about medical services.

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

# CHAPTER 7:
# If you have a problem or complaint (coverage decisions, appeals, complaints)

## SECTION 1 What to do if you have a problem or concern

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

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

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

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

### Section 1.1 Legal terms

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

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

## SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at 1-888-777-5536 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help you are:

**State Health Insurance Assistance Program (SHIP)**

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can

help you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. Call your local SHIP at Maryland Department of Aging: 1-410-767-1100 or toll free 1-800-243-3425 (TTY 711), District of Columbia Department of Aging and Community Living: 1-202-724-5626 (TTY 711), or Virginia Insurance Counseling and Assistance Program: 1-804-662-9333 or toll free 1-800-552-3402 (TTY 711). You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

**Medicare**

You can also contact Medicare for help.

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048
- Visit Medicare.gov

## SECTION 3 Which process to use for your problem

**Is your problem or concern about your benefits or coverage?**

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

**Yes.**

Go to **Section 4, A guide to coverage decisions and appeals.**

**No.**

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

# Coverage decisions and appeals

## SECTION 4 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems about your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical**

**care**. You may use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

### Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuse 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 on to a Level 2 appeal conducted by an independent review organization not connected to us.

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

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

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

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

- **Call Member Services at 1-888-777-5536 (TTY users call 711)**
- **Get free help** from your State Health Insurance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at 1-888-777-5536 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at 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.
- **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 another person to be your representative, call Member Services at 1-888-777-5536 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at kp.org. This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
    - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right

to ask the independent review organization to review our decision to dismiss your appeal.

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

### Section 4.2 Rules and deadlines for different situations

There are 3 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations:

- **Section 5:** Medical care: How to ask for a coverage decision or make an appeal
- **Section 6:** How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon
- **Section 7:** How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies to only these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure information applies to you, call Member Services at 1-888-777-5536 (TTY users call 711). You can also get help or information from your SHIP.

## SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

### Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**

3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an Appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5**
5. You're being told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an Appeal. Section 5.3**

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

### Section 5.2 How to ask for a coverage decision

**Legal Terms:**

A coverage decision that involves your medical care is called an **organization determination.**

A fast coverage decision is called an **expedited determination.**

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

**A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:**

- You may *only ask* for coverage for medical care items and/or services (not requests for payment for items and/or services you already got).
- You can get a fast coverage decision *only* if using the standard deadlines could cause serious harm to your health or hurt your ability to regain function.

**If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.**

**If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.

- Explains that you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

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

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

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

***For standard coverage decisions, we use the standard deadlines***.

**This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to 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 Section 9 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 we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 9 of this chapter for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

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

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

## Section 5.3 How to make a Level 1 appeal

**Legal Terms:**

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

A fast appeal is also called an **expedited reconsideration**.

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

**A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.**

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

**Step 2: Ask our plan for an Appeal or a Fast Appeal**

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We're allowed to charge a fee for copying and sending this information to you.

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

- When our plan is reviewing your appeal, we take a careful look at all the information. We check to see if we were following 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 to Level 2 of the appeals process, where it will be reviewed by an independent review organization. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage 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 our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it 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 get your appeal. We'll give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
    - If you believe we shouldn't take extra days, you can file a fast complaint. When you file a *fast complaint*, we'll give you an answer to your complaint within 24 hours. (Go to Section 9 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. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within **30 calendar days** if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal,** we'll automatically send your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

### Section 5.4 The Level 2 appeal process

**Legal Term:**

The formal name for the independent review organization is the **Independent Review Entity**. It's sometimes called the **IRE**.

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

**Step 1: The independent review organization reviews your appeal.**

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We're allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information related to 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**. If they take extra days, they will notify you in writing. 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**. If they take extra days, they will notify you in writing. 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 they agree with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision or turning down your appeal.**) In this case, the independent review organization will send you a letter that:
    - Explains the decision.
    - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.

- Tells you how to file a Level 3 appeal.

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 explains the Level 3, 4, and 5 appeals processes.

### Section 5.5 If you're asking us to pay for our share of a bill you got for medical care

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

**Asking for reimbursement is asking for a coverage decision from us**

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

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're asking us to change the coverage decision we made when we turned down your request for payment.

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

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes

at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

## SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

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

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

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

### Section 6.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called An Important Message from Medicare about Your Rights. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at 1-888-777-5536 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about 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.
2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Member Services at 1-888-777-5536 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at CMS.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

### Section 6.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are:

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help, call Member Services at 1-888-777-5536 (TTY users call 711). Or call your State Health Insurance Program (SHIP) for personalized help. Call your local SHIP at Maryland Department of Aging: 1-410-767-1100 or toll free 1-800-243-3425 (TTY 711), District of Columbia Department of Aging and Community Living: 1-202-724-5626 (TTY 711), or Virginia Insurance Counseling and Assistance Program: 1-804-662-9333 or toll free 1-800-552-3402 (TTY 711). SHIP contact information is available in Chapter 2, Section 3.

**During a Level 1 appeal, the Quality Improvement Organization reviews your appeal.** It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals who are paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

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

***How can you contact this organization?***

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

***Act quickly:***

- To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and **no later than midnight the day of your discharge.**
    - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
    - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all 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's right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at 1-888-777-5536 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048.) Or you can get a sample notice online at 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's right (medically appropriate) for you to be discharged on that date.

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

***What happens if the answer is yes?***

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

***What happens if the answer is no?***

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

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

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

## Section 6.3 How to make a Level 2 appeal to change your hospital discharge date

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

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

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

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

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

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

***If the 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's medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

***If the independent review organization says no:***

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

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

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

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

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

When we decide it's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

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

### Section 7.1 We'll tell you in advance when your coverage will be ending

**Legal Term:**

**Notice of Medicare Non-Coverage.** It tells you how you can ask for a **fast-track appeal**.

Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

**1. You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:

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

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

### Section 7.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help, call Member Services at 1-888-777-5536 (TTY users call 711). Or call your State Health Insurance Program (SHIP) for personalized help. Call your local SHIP at Maryland Department of Aging: 1-410-767-1100 or toll free 1-800-243-3425 (TTY 711), District of Columbia Department of Aging and Community Living: 1-202-724-5626 (TTY 711), or Virginia Insurance Counseling and Assistance Program: 1-804-662-9333 or toll free 1-800-552-3402 (TTY 711). SHIP contact information is available in Chapter 2, Section 3.

**During a Level 1 appeal, the Quality Improvement Organization reviews your appeal**. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts who are paid by the federal

government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

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

***How can you contact this organization?***

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

***Act quickly*:**

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the Notice of Medicare Non-coverage. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

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

**Legal Term:**

**Detailed Explanation of Non-Coverage.** Notice that gives details on reasons for ending coverage.

***What happens during this review?***

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

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

***What happens if the reviewers say yes?***

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

***What happens if the reviewers say no?***

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

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

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

## Section 7.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

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

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

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

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

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

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

***What happens if the independent review organization says yes?***

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

***What happens if the independent review organization says no?***

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

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

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

## SECTION 8 Taking your appeal to Levels 3, 4 and 5

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

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

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

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first two 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.

## Making complaints

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

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

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

| Complaint | Example |
|---|---|
| **Quality of your medical care** | • Are you unhappy with the quality of the care you got (including care in the hospital)? |
| **Respecting your privacy** | • Did someone not respect your right to privacy or share confidential information? |
| **Disrespect, poor customer service, or other negative behaviors** | • Has someone been rude or disrespectful to you?<br>• Are you unhappy with our Member Services?<br>• 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?<br>• Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan? |

| Complaint | Example |
|---|---|
| | ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription. |
| **Cleanliness** | • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office? |
| **Information you get from us** | • Did we fail to give you a required notice?<br>• Is our written information hard to understand? |
| **Timeliness**<br>(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:<br>• You asked us for a *fast coverage decision* or a *fast appeal*, and we said no; you can make a complaint.<br>• You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint.<br>• You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint.<br>• You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint. |

## Section 9.2 How to make a complaint

**Legal Terms:**

A **complaint** is also called a **grievance**.

**Making a complaint** is called **filing a grievance**.

**Using the process for complaints** is called **using the process for filing a grievance**.

A **fast complaint** is called an **expedited grievance**.

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

- **Calling Member Services at 1-888-777-5536 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Member Services will let you know.

- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing. We'll also respond in writing when you make a complaint by phone if you request a written response or your complaint is related to quality of care.
- **If you have a complaint, we will try to resolve your complaint over the phone.** If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. Your grievance must explain your concern, such as why you are dissatisfied with the services you received. Please see Chapter 2 for whom you should contact if you have a complaint.
    - 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.

## Section 9.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 extra options:

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

*Or*

- **You can make your complaint to both the Quality Improvement Organization and us at the same time**.

## Section 9.4 You can also tell Medicare about your complaint

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

# CHAPTER 8:
# Ending membership in our plan

## SECTION 1 Ending your membership in our plan

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

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care, and you'll continue to pay your cost share until your membership ends.

## SECTION 2 When can you end your membership in our plan?

### Section 2.1 You can end your membership during the Open Enrollment Period

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Open Enrollment Period** is from **October 15 to December 7.**
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of coverage:
    - Another Medicare health plan, with or without drug coverage,
    - Original Medicare *with* a separate Medicare drug plan,
    - Original Medicare *without* a separate Medicare drug plan.
- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

### Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and, for new Medicare enrollees in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period**, you can:
    - Switch to another Medicare Advantage Plan with or without drug coverage.
    - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

## Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of our plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

**You may be eligible to end your membership during a Special Enrollment Period** if any of the following situations apply. These are just examples. For the full list you can contact our plan, call Medicare, or visit Medicare.gov.

- Usually, when you move
- If you have Medicaid
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)

**Enrollment time periods vary** depending on your situation.

**To find out if you're eligible for a Special Enrollment Period**, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage.
- Original Medicare *with* a separate Medicare drug plan.
- Original Medicare *without* a separate Medicare drug plan.

**Your membership will usually end** on the first day of the month after we get your request to change your plan.

### Section 2.4 Get more information about when you can end your membership

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

- **Call Member Services at 1-888-777-5536 (TTY users call 711)**
- Find the information in the ***Medicare & You 2027*** handbook
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227**)** TTY users call 1-877-486-2048

## SECTION 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan.

| To switch from our plan to: | Here's what to do: |
|---|---|
| **Another Medicare health plan** | • Enroll in the new Medicare health plan.<br>• You'll automatically be disenrolled from our plan when your new plan's coverage starts. |
| **Original Medicare *with* a separate Medicare drug plan** | • Enroll in the new Medicare drug plan.<br>• You'll automatically be disenrolled from our plan when your new plan's coverage starts. |
| **Original Medicare *without* a separate Medicare drug plan** | • **Send us a written request to disenroll**. Call Member Services at 1-888-777-5536 (TTY users call 711) if you need more information on how to do this.<br>• You can also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048.<br>• You'll be disenrolled from our plan when your coverage in Original Medicare starts. |

**Note**: If you also have creditable prescription drug coverage (e.g., a separate Medicare drug plan) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable prescription drug coverage for 63 days or more in a row.

## SECTION 4 Until your membership ends, you must keep getting your medical items and services through our plan

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

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

## SECTION 5 We must end your plan membership in certain situations

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

- If you no longer have Medicare Part A and Part B
- If you move out of our service area
- If you're away from our service area for more than 6 months
    - If you move or take a long trip, call Member Services at 1-888-777-5536 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or national, or eligible noncitizen
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan (We can't make you leave our plan for this reason unless we get permission from Medicare first)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan (We can't make you leave our plan for this reason unless we get permission from Medicare first)
- If you let someone else use your membership card to get medical care (We can't make you leave our plan for this reason unless we get permission from Medicare first)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General

If you have questions or want more information on when we can end your membership, call Member Services at 1-888-777-5536 (TTY users call 711).

## Section 5.1 We can't ask you to leave our plan for any health-related reason

We aren't allowed to ask you to leave our plan for any health-related reason.

### What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

## Section 5.2 You have the right to make a complaint if we end your membership in our plan

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

# CHAPTER 9: Legal notices

## SECTION 1 Notice about governing law

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

## SECTION 2 Notice about nondiscrimination

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

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

If you have a disability and need help with access to care, call Member Services at 1-888-777-5536 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

## SECTION 3 Notice about Medicare Secondary Payer subrogation rights

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

## SECTION 4 Administration of this *Evidence of Coverage*

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

## SECTION 5 Applications and statements

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

## SECTION 6 Assignment

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

## SECTION 7 Attorney and advocate fees and expenses

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

## SECTION 8 Coordination of benefits

As described in Chapter 1, Section 7, "How other insurance works with our plan," if you have other insurance, you are required to use your other coverage in combination with your coverage as a Kaiser Permanente Medicare Advantage Liberty member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. You will get your covered care as usual from network providers, and the other coverage you have will simply help pay for the care you receive.

If your other coverage is the primary payer, it will often settle its share of payment directly with us, and you will not have to be involved. However, if payment owed to us by a primary payer is sent directly to you, you are required by Medicare law to give this primary payment to us. For more information about primary payments in third party liability situations, see Section 16 in this chapter, and for primary payments in workers' compensation cases, see Section 18 in this chapter.

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

## SECTION 9 Employer responsibility

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

## SECTION 10 *Evidence of Coverage* binding on members

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

## SECTION 11 Government agency responsibility

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

## SECTION 12 Member nonliability

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

## SECTION 13 No waiver

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

## SECTION 14 Notices

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

## SECTION 15 Overpayment recovery

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

## SECTION 16 Third party liability

As stated in Chapter 1, Section 7, third parties who cause you injury or illness (and/or their insurance companies) usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue these primary payments. If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered services, you must ensure we receive reimbursement for those services.

**Note:** This "Third party liability" section does not affect your obligation to pay cost-sharing for these services.

To the extent permitted or required by law, we shall be subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain against a third party that results in any settlement proceeds or judgment, from other types of coverage that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, workers' compensation, personal injury, medical payments and all other first party types. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether you are made whole and regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred. We are not required to pay attorney fees or costs to any attorney hired by you to pursue your damages claim. If you reimburse us without the need for legal action, we will allow a procurement cost discount. If we have to pursue legal action to enforce its interest, there will be no procurement discount.

Within 30 days after submitting or filing a claim or legal action against a third party, you must send written notice of the claim or legal action to:

Kaiser Permanente
Attention: Patient Financial Services Department
4000 Garden City Drive
Hyattsville, Maryland 20785

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

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

## SECTION 17 U.S. Department of Veterans Affairs

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

## SECTION 18 Workers' compensation or employer's liability benefits

As stated in Chapter 1, Section 7, workers' compensation usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue primary payments under workers' compensation or employer's liability law. You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered services from the following sources:

- From any source providing a Financial Benefit or from whom a Financial Benefit is due.
- From you, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

## SECTION 19 Surrogacy

In situations where a member receives monetary compensation to act as a surrogate, our plan will seek reimbursement of all Plan Charges for covered services the member receives that are associated with conception, pregnancy and/or delivery of the child. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

# CHAPTER 10: Definitions

**Advantage Plus – (Optional Supplemental Benefits)** – Non-Medicare-covered benefits that can be purchased for an additional premium and aren't included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits in order to get them. **The two supplemental benefits packages offered include eyewear, hearing aid, and comprehensive dental benefits or only comprehensive dental** benefits for an additional monthly premium that is added to your Kaiser Permanente Medicare Advantage Liberty plan premium (see Chapter 1, Section 4.3, for more information).

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

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

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

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

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

**Centers for Medicare & Medicaid Services (CMS)** – The federal agency that administers Medicare.

**Coinsurance** – An amount you may be required to pay, expressed as a percentage (for example 20%) of Plan Charges as your share of the cost for services.

**Complaint** – The formal name for making a complaint is **filing a grievance**. The complaint process is used only for certain types of problems. This includes problems 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 Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

**Coordination of Benefits (COB)** – Coordination of Benefits is a provision used to establish the order in which claims are paid when you have other insurance. If you have Medicare and other health insurance or coverage, each type of coverage is called a payer. When there is more than one payer, there are coordination of benefits rules that decide which one pays first. The primary payer pays what it owes on your bills first, and then sends the rest to the secondary payer to pay. If payment owed to us is sent directly to you, you're required under Medicare law to give the payment to us. In some cases, there may also be a third payer. See Chapter 1, Section 7, and Chapter 9, Section 8, for more information.

**Copayment (or copay)** – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

**Cost-Sharing** – Cost-sharing refers to amounts that a member has to pay when services are gotten. Cost-sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services are covered; 2) any fixed *copayment* amount that a plan requires when a specific service is gotten; or 3) any *coinsurance* amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is gotten. **Note:** In some cases, you may not pay all applicable cost-sharing at the time you receive the services and we will send you a bill later for the cost-sharing. For example, if you receive non-preventive care during a scheduled preventive care visit, we may bill you later for the cost-sharing applicable to the non-preventive care. For items ordered in advance, you pay the cost-sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the cost-sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription.

**Covered Services** – The term we use to mean all the health care services and supplies that are covered by our plan.

**Creditable Prescription Drug Coverage** – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they

become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

**Custodial Care** – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

**Deductible** – The amount you must pay for health care before our plan pays.

**Disenroll** or **Disenrollment** – The process of ending your membership in our plan.

**Dual Eligible Special Needs Plans (D-SNP) –** D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the person's eligibility.

**Dually Eligible Individual –** A person who is eligible for Medicare and Medicaid coverage.

**Durable Medical Equipment (DME)** – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

**Emergency Care** – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

**Emergency Medical Condition** – A medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;

- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

**Evidence of Coverage (EOC) and Disclosure Information** – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

**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.

**Grievance** – A type of complaint you make about our plan or providers, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

**Home Health Aide** – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

**Home Health Care** – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Medical Benefits Chart in Chapter 4, Section 2. We cover home health care in accord with Medicare guidelines. Home health care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you're also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

**Hospice** – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

**Hospital Inpatient Stay –** A hospital stay when you've been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

**Initial Enrollment Period –** When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

**Inpatient Hospital Care –** Health care that you get during an inpatient stay in an acute care general hospital.

**Kaiser Foundation Health Plan (Health Plan) –** Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. is a nonprofit corporation and a Medicare Advantage organization. This *Evidence of Coverage* sometimes refers to Health Plan as "we" or "us" (and it applies to Kaiser Permanente Medicare Advantage Liberty plan members).

**Kaiser Permanente –** Health Plan and Medical Group.

**Kaiser Permanente Region (Region) –** A Kaiser Foundation Health Plan organization that conducts a direct-service health care program. When you're outside our service area, you can get medically necessary health care and ongoing care for chronic conditions from designated providers in another Kaiser Permanente Region's service area. For more information, please refer to Chapter 3, Section 2.4.

**Long-Term Care Hospital** – A Medicare-certified acute-care hospital that typically provides Medicare covered services such as comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. They are not long-term care facilities such as convalescent or assisted living facilities.

**Low Income Subsidy (LIS)** – Go to Extra Help.

**Maximum Out-of-Pocket Amount** – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums and Medicare Part A and Part B premiums don't count toward the maximum out-of-pocket amount.

**Medicaid (or Medical Assistance)** – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

**Medical Care or Services** – Health care services or items. Some examples of health care items include durable medical equipment, eyeglasses, and drugs covered by Medicare Part A or Part B.

**Medical Group** – It is the network of plan providers that our plan contracts with to provide covered services to you. The name of our medical group is the Mid-Atlantic Permanente Medical Group, P.C, a for-profit professional corporation.

**Medically Necessary** – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

**Medicare** – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

**Medicare Advantage Open Enrollment Period** – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

**Medicare Advantage (MA) Plan** – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Kaiser Permanente Medicare Advantage Liberty doesn't offer Medicare prescription drug coverage.

**Medicare-Covered Services –** Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

**Medicare Health Plan** – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

**Medicare Prescription Drug Coverage (Medicare Part D)** – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

**Medigap (Medicare Supplement Insurance) Policy** – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

**Member (Member of our Plan, or Plan Member)** – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

**Member Services** – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

**Network Physician** – Any licensed physician who is a partner or employee of Medical Group, or any licensed physician who contracts to provide services to our members (but not including physicians who contract only to provide referral services).

**Network Provider – Provider** is the general term for doctors, other health care professionals (including, but not limited to, physician assistants, nurse practitioners, and nurses), hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

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

**Organization Determination** – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

**Original Medicare (Traditional Medicare or Fee-for-Service Medicare)** – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

**Out-of-Network Provider or Out-of-Network Facility** – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

**Out-of-Pocket Costs** – Go to the definition for cost-sharing above. A member's cost-sharing requirement to pay for a portion of services gotten is also referred to as the member's out-of-pocket cost requirement.

**PACE Plan** – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

**Part C –** Go to Medicare Advantage (MA) Plan.

**Part D** – The voluntary Medicare Prescription Drug Benefit Program.

**Plan** – Kaiser Permanente Medicare Advantage Liberty

**Plan Charges** – Plan Charges means the following:

- For services provided by Medical Group or plan hospitals, the charges in Health Plan's schedule of Medical Group and plan hospitals charges for services provided to members.
- For services for which a provider (other than Medical Group or plan hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider.
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a member for the item if a member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs; the direct and indirect costs of providing Kaiser Permanente pharmacy services to members; and the pharmacy program's contribution to the net revenue requirements of Health Plan).
- For all other services, the payments that Kaiser Permanente makes for the services or, if Kaiser Permanente subtracts cost-sharing from its payment, the amount Kaiser Permanente would have paid if it did not subtract cost-sharing.

**Post-Stabilization Care** – Medically necessary services related to your emergency medical condition that you receive after your treating physician determines that this condition is clinically stable. You're considered clinically stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards that you're safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

**Preferred Provider Organization (PPO) Plan** – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they're received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

**Premium** – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

**Preventive services** – Health care to services that help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases.

Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health.

**Primary Care Provider (PCP)** – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

**Prior Authorization** – Approval in advance to get services based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4 and described in Chapter 3, Section 2.3.

**Prosthetics and Orthotics** – Medical devices including, but not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy and urological supplies and enteral and parenteral nutrition therapy.

**Quality Improvement Organization (QIO)** – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

**Referral** – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

**Rehabilitation Services** – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

**Service Area** – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. We must disenroll you if you permanently move out of our plan's service area.

**Services** – Health care services, supplies, or items.

**Skilled Nursing Facility (SNF) Care –** Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

**Special Enrollment Period –** A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

**Special Needs Plan –** A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

**Supplemental Security Income (SSI) –** A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

**Urgently Needed Services –** A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

KAISER PERMANENTE®

**Kaiser Permanente Medicare Advantage Member Services**

| Method | Member Services – Contact Information |
|---|---|
| **Call** | **1-888-777-5536**<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.<br>Member Services 1-888-777-5536 (TTY users call 711) also has free language interpreter services available for non-English speakers. |
| **TTY** | **711**<br>Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. |
| **Write** | Kaiser Permanente<br>Member Services<br>Nine Piedmont Center<br>3495 Piedmont Road, NE<br>Atlanta, GA 30305-1736 |
| **Website** | kp.org |

**State Health Insurance Assistance Program**

A State Health Insurance Assistance Program (SHIP) is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. Please see Chapter 2, Section 3, for SHIP contact information.

***PRA Disclosure Statement*** *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*