January 1 – December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services and Drug coverage as a Member of Kaiser Permanente Dual Complete (HMO D-SNP)

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

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

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

For questions about this document, call Member Services at 1-800-805-2739 (TTY users call 711). Hours are 7:45 a.m. to 8 p.m., 7 days a week. This call is free.

This plan, Kaiser Permanente Dual Complete, is offered by Kaiser Foundation Health Plan, 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 Dual Complete (Dual Complete).

This document is available for free in Chinese, Ilocano, Korean, and Vietnamese.

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

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

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

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OMB Approval 0938-1051 (Expires: August 31, 2026)

KAISER PERMANENTE®

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CHAPTER 1: Get started as a member

SECTION 1 You're a member of Kaiser Permanente Dual Complete

Section 1.1 You're enrolled in Kaiser Permanente Dual Complete, which is a Medicare Special Needs Plan

You're covered by both Medicare and Medicaid:

- **Medicare** is 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 (kidney failure).
- **Medicaid** is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that aren't covered by Medicare.

You've chosen to get your Medicare health care and your drug coverage through our plan, Kaiser Permanente Dual Complete. Our plan covers all Part A and Part B services. However, cost sharing and provider access in our plan differ from Original Medicare.

Kaiser Permanente Dual Complete is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means benefits are designed for people with special health care needs. Kaiser Permanente Dual Complete is designed for people who have Medicare and are entitled to help from Medicaid.

Because you get help from Medicaid with Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance), you may pay nothing for your Medicare services. Medicaid may also provide other benefits by covering health care services, prescription drugs, long-term care and/or home and community-based services that aren't usually covered under Medicare. You'll also get Extra Help from Medicare to pay for the costs of your Medicare drugs. Our plan will help you manage all these benefits, so you get the health services and payment help that you're entitled to.

Kaiser Permanente Dual Complete is run by a non-profit organization. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. Our plan also has a contract with the Hawaii Medicaid program to coordinate your Medicaid benefits. We're pleased to provide your Medicare coverage, including drug coverage.

This *Evidence of Coverage* describes the following plans, which include Medicare Part D prescription drug coverage:

- Kaiser Permanente Dual Complete Maui (HMO D-SNP)— referred to in this document as "Maui plan."
- Kaiser Permanente Dual Complete Oahu (HMO D-SNP)— referred to in this document as "Oahu plan."

If you are not certain which plan you are enrolled in, please call Member Services or refer to the cover of your *Annual Notice of Change* (or for new members, your enrollment form or enrollment confirmation letter).

Note: Please refer to Section 2.2 in this chapter for the geographic service area of each plan included in this *Evidence of Coverage*. For the purposes of premiums, cost-sharing, enrollment, and disenrollment, there are multiple Dual Complete plans in our Region's service area, which are described in this *Evidence of Coverage*. But, for the purposes of obtaining covered services, you get care from network providers anywhere inside our Region's service area.

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, the *2026 Comprehensive Formulary*, and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in Kaiser Permanente Dual Complete between January 1, 2026, and December 31, 2026.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of our plan after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) and the Department of Human Services Med QUEST Division(Medicaid) must approve our plan. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare and the Department of Human Services Med QUEST Division(Medicaid) 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 2.3). People who are incarcerated aren't considered to be living in the geographic service area even if they're physically located in it.
- You're a United States citizen or lawfully present in the United States
- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who get certain Medicaid benefits. (Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for Medicare and full Medicaid benefits. Your Medicaid plan must be enrolled with Kaiser Permanente.

Note: If you lose your eligibility but can reasonably be expected to regain eligibility within 6 months, then you're still eligible for membership. Chapter 4, Section 2 tells you about coverage and cost sharing during a period of deemed continued eligibility.

Section 2.2 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who's eligible, what services are covered, and the cost for services. States also can decide how to run its program as long as they follow the federal guidelines.

In addition, Medicaid offers programs to help people pay their Medicare costs, such as their Medicare premiums. These Medicare Savings Programs help people with limited income and resources save money each year:

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

Section 2.3 Plan service area for Kaiser Permanente Dual Complete

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.

Kaiser Permanente Dual Complete Maui (for persons who live in this plan's service area)

Our service area includes these parts of **Maui County** in Hawaii, **in the following ZIP codes only**: 96708, 96713, 96732, 96733, 96753, 96761, 96767, 96768, 96779, 96784, 96788, 96790, and 96793.

Kaiser Permanente Dual Complete Oahu (for persons who live in this plan's service area)

Our service area includes **Honolulu County** in Hawaii.

If you plan to move to a new state, you should also contact your state's Medicaid office and ask how this move will affect your Medicaid benefits. Phone numbers for Medicaid are in Chapter 2, Section 6 of this document.

If you move out of our plan's service area, you can't stay a member of this plan. Call Member Services at 1-800-805-2739 (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 or drug 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).

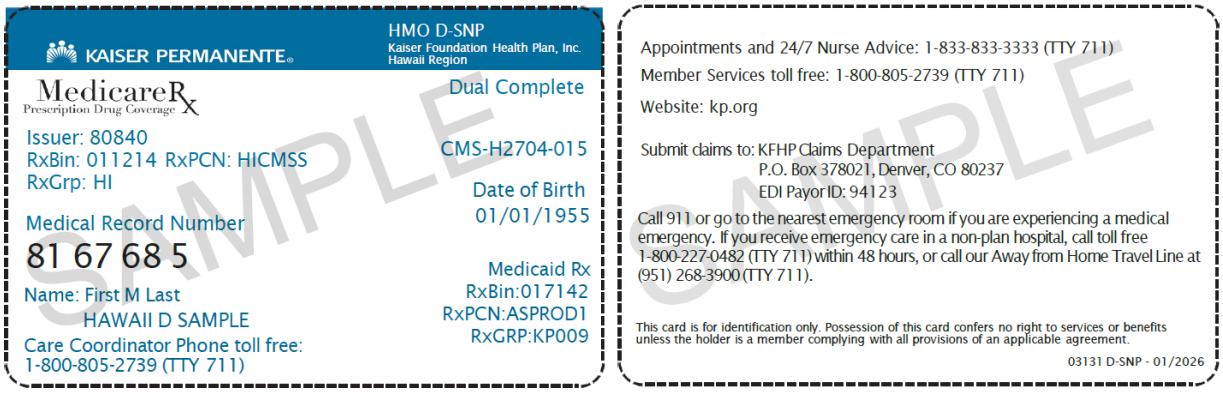
Section 2.4 U.S. citizen or lawful presence

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

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Under our plan, you have one card for your Medicare and Medicaid services. While you are a member of our plan, you must use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. 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 Dual Complete 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 1-800-805-2739 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider and Pharmacy Directory

The *Provider and Pharmacy 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.

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

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

If you don't have a copy of the *Provider and Pharmacy Directory*, you can ask for a copy (electronically or in paper form) from Member Services at 1-800-805-2739 (TTY users call 711). Requested paper *Provider and Pharmacy Directories* will be mailed to you within 3 business days. You can also find this information on our website at kp.org/directory.

Section 3.3 Drug List (formulary)

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

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

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit kp.org/seniorrx or call Member Services at 1-800-805-2739 (TTY users call 711).

SECTION 4 Summary of important costs

	Your Costs in 2026
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 4.1 for details.	• **Maui plan - $0** • **Oahu plan - $0**
Maximum out-of-pocket amount This is the most you'll pay out-of-pocket for covered Part A and Part B services. (Go to Chapter 4, Section 1 for details.)	**If you are eligible for Medicare cost-sharing help under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. If you lose your Medicaid coverage, you pay:** • **Maui plan - $9,250** • **Oahu plan - $9,250**

	Your Costs in 2026
Primary care office visits	**If you are eligible for Medicare cost-sharing help under Medicaid, you pay $0 per visit. If you lose your Medicaid coverage, you pay:** • **Maui plan - $40** • **Oahu plan - $40**
Specialist office visits	**If you are eligible for Medicare cost-sharing help under Medicaid, you pay $0 per visit. If you lose your Medicaid coverage, you pay:** • **Maui plan - $55** • **Oahu plan - $55**
Inpatient hospital stays	**Cost-sharing is charged for each inpatient stay.** **If you are eligible for Medicare cost-sharing help under Medicaid, you pay $0 per admission. If you lose your Medicaid coverage, you pay:** • **Maui plan - Per admission, $405 per day for days 1–6 and $70 per day for days 7-30.** • **Oahu plan- Per admission, $405 per day for days 1–6 and $70 per day for days 7-30.**

	Your Costs in 2026
	You pay $0 for the rest of your stay.
Part D drug coverage deductible (Go to Chapter 6, Section 4 for details.)	**Maui plan - $615 (Tiers 3, 4, and 5, if you don't qualify for "Extra Help"), except for covered insulin products and most adult Part D vaccines.** **Oahu plan - $615 (Tiers 4 and 5, if you don't qualify for "Extra Help"), except for covered insulin products and most adult Part D vaccines.**
Part D drug coverage (Go to Chapter 6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	**Cost-sharing during the Initial Coverage Stage if you don't qualify for "Extra Help". You pay $0 per month supply of each covered insulin product in all tiers.** **Drug Tier 1:** • **Maui plan - $0** • **Oahu plan - $0** **Drug Tier 2:** • **Maui plan - $0** • **Oahu plan - $0** **Drug Tier 3:** • **Maui plan - 17%** • **Oahu plan - 25%** **Drug Tier 4:** • **Maui plan - 25%**

	Your Costs in 2026
	• **Oahu plan - 25%** **Drug Tier 5:** • **Maui plan - 25%** • **Oahu plan - 25%** **Drug Tier 6:** • **Maui plan - $0** • **Oahu plan - $0** **You won't pay more than $0 for up to a one-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.** **Catastrophic Coverage Stage:** **During this payment stage, you pay nothing for your covered Part D drugs.**

Your costs may include the following:

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

Section 4.1 Plan premium

You don't pay a separate monthly plan premium for Kaiser Permanente Dual Complete.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

Some members are required to pay other Medicare premiums. As explained in Section 2 above to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most of our plan members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and Part B premium.

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

Section 4.3 Part D Late Enrollment Penalty

Because you're dually-eligible, the LEP doesn't apply as long as you maintain your dually-eligible status, but if you lose your dually-eligible status, you may incur an LEP. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there was a period of 63 days or more in a row when you didn't have Part D or other creditable drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You'll have to pay this penalty for as long as you have Part D coverage.

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

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

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

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you did not have creditable drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty percentage will be 14%.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2026, this average premium amount is $38.99.
- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium and round to the nearest 10 cents. In the example here, it would be 14% times $38.99, which equals $5.45. This rounds to $5.50. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty**.

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

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

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

Section 4.4 Income Related Monthly Adjustment Amount

If you lose eligibility for this plan because of changes income, some members may be required to pay an extra charge for their Medicare plan, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA.

For more information on the extra amount you may have to pay based on your income, visit www.Medicare.gov/health-drug-plans/part-d/basics/costs.

If you have to pay an extra IRMAA, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay our plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you'll get a bill from Medicare. **You must pay the extra IRMAA to the government. It can't be paid with your monthly plan premium. If you don't pay the extra IRMAA, you'll be disenrolled from our plan and lose prescription drug coverage.**

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

Section 4.5 Medicare Prescription Payment Plan Amount

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

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

SECTION 5 More information about your monthly plan premium

Section 5.1 Our monthly plan premium won't change during the year

We're not allowed to change our 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.

However, in some cases, you may be able to stop paying a late enrollment penalty, if you owe one, or you may need to start paying a late enrollment penalty. This could happen if you become eligible for Extra Help or lose your eligibility for Extra Help during the year.

- If you currently pay a Part D late enrollment penalty and become eligible for Extra Help during the year, you'd be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the Part D late enrollment penalty if you go 63 days or more in a row without Part D or other creditable drug coverage.

Find out more about Extra Help in Chapter 2, Section 7.

SECTION 6 Keep our plan membership record up to date

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

The doctors, hospitals, pharmacists, and other providers in our plan's network **use your membership record to know what services and drugs are covered and your cost-sharing amounts.** Because of this, it's very important 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 1-800-805-2739 (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 1-800-805-2739 (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 all 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 and/or employer group health plans have paid.

CHAPTER 2:
Phone numbers and resources

SECTION 1 Kaiser Permanente Dual Complete contacts

For help with claims, billing, or member card questions, call or write to Kaiser Permanente Dual Complete Member Services. We'll be happy to help you.

Member Services – Contact Information	
Call	1-800-805-2739 Calls to this number are free. 7 days a week, 7:45 a.m. to 8 p.m. Member Services 1-800-805-2739 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. 7 days a week, 7:45 a.m. to 8 p.m.
Write	Kaiser Permanente Member Services 711 Kapiolani Blvd. Honolulu, HI 96813
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 about your medical care, go to Chapter 9.

Coverage Decisions for Medical Care – Contact Information	
Call	1-800-805-2739 Calls to this number are free. 7 days a week, 7:45 a.m. to 8 p.m.
TTY	711 Calls to this number are free. 7 days a week, 7:45 a.m. to 8 p.m.

Coverage Decisions for Medical Care – Contact Information	
Fax	808-432-5691
Write	Kaiser Permanente Attn: Authorizations and Referral Management 2828 Paa Street Honolulu, HI 96819
Website	kp.org

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

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

Coverage Decisions for Part D Drugs – Contact Information	
Call	1-888-277-3917 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
TTY	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
Fax	1-844-403-1028
Write	OptumRx c/o Prior Authorization P.O. Box 2975 Mission, KS 66201
Website	kp.org

How to contact us when you are making an appeal about your medical care or Part D drugs

An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for appeals about your medical care or Part D drugs, go to Chapter 9.

Appeals for Medical Care or Part D Drugs – Contact Information	
Call	1-800-805-2739 Calls to this number are free. 7 days a week, 7:45 a.m. to 8 p.m. If your appeal qualifies for a fast decision as described in Chapter 9, Call 1-866-233-2851 or 808-432-7503. 7 days a week, 8 a.m. to 8 p.m.
TTY	711 Calls to this number are free. 7 days a week, 7:45 a.m. to 8 p.m.
Fax	808-432-5260
Write	Kaiser Permanente Attn: Member Relations 711 Kapiolani Blvd. Honolulu, HI 96813 Email address: KPHawaii.appeals@kp.org
Website	kp.org

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

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care or Part D drugs, go to Chapter 9.

Complaints about Medical Care or Part D Drugs – Contact Information	
Call	1-800-805-2739 Calls to this number are free. 7 days a week, 7:45 a.m. to 8 p.m.
TTY	711 Calls to this number are free. 7 days a week, 7:45 a.m. to 8 p.m.
Fax	808-432-5260

Complaints about Medical Care or Part D Drugs – Contact Information	
Write	Kaiser Permanente Attn: Member Relations 711 Kapiolani Blvd. Honolulu, HI 96813
Medicare website	To submit a complaint about our plan directly to Medicare, go to www.Medicare.gov/my/medicare-complaint.

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

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

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

Payment Requests – Contact Information	
Call	1-877-875-3805 Calls to this number are free. Monday through Friday, 8 a.m. to 5 p.m.
TTY	711 Calls to this number are free. Monday through Friday, 8 a.m. to 5 p.m.
Write	Kaiser Permanente Claims Department Hawaii Region P.O. Box 378021 Denver, CO 80237
Website	kp.org

SECTION 2 Get help from Medicare

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

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

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

Medicare – Contact Information	
	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. In Hawaii, the SHIP is called Hawaii State Health Insurance Assistance Program (Hawaii SHIP).

Hawaii 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.

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

Hawaii SHIP - Contact Information	
Call	1-888-875-9229 Calls to this number are free. Monday through Sunday: pre-recorded helpline (Calls will be returned within 5 business days or less).
TTY	1-866-810-4379 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Executive Office on Aging No. 1 Capitol District 250 South Hotel Street, Suite 406 Honolulu, Hawaii 96813-2831
Website	www.hawaiiship.org

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For Hawaii, the Quality Improvement Organization is called Commence Health.

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

Contact Commence Health in any of these situations:

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

Commence Health (Hawaii's Quality Improvement Organization) – Contact Information	
Call	1-877-588-1123 Calls to this number are free. Monday through Friday, 9 a.m. to 5 p.m. Weekends and holidays, 10 a.m. to 4 p.m.
TTY	711
Write	Commence Health BFCC-QIO Program P.O. Box 2687 Virginia Beach, VA 23450
Website	www.livantaqio.cms.gov/en

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment. Social Security is also responsible for determining who has to pay an extra amount for Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount,

or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

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

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

SECTION 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the federal guidelines.

To be eligible for our plan, you must be eligible for both Medicare and Medicaid. Your eligibility for Medicaid is determined annually and may change during the current plan year. Please note: If you lose your Medicaid eligibility but can reasonably be expected to regain eligibility within 6 month(s), then you are still eligible for membership in our plan. This is called a period of deemed continued eligibility. However, during this period, your cost-sharing and premiums you pay us may change. Please see Chapter 4, Section 2, for additional information about coverage and cost-sharing during a period of deemed continued eligibility.

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

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

If you have questions about the help you get from Medicaid, contact the State of Hawaii Department of Human Services Med-QUEST Division.

State of Hawaii Department of Human Services Med QUEST Division – Contact Information	
Call	1-800-316-8005 Monday through Friday, 7:45 a.m. to 4:30 p.m.
TTY	711
Write	To identify a mailing address for an office location near you, please visit https://medquest.hawaii.gov/en/contact-us.html
Website	www.medquest.hawaii.gov

The Hawaii Department of Health Care Services Office of the Ombudsman helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan.

Hawaii Medicaid Ombudsman – Contact Information	
Call	1-888-488-7988 Calls to this number are free. Monday through Friday, 7:45 a.m. to 4:30 p.m. (excluding Hawaii state holidays)
TTY	711
Write	Koan Risk Solutions 1580 Makaloa St. #550 Honolulu, HI 96814
Website	www.himedicaidombudsman.com/
Email	hiombudsman@koanrisksolutions.com

The Hawaii State Long-Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Hawaii Long-Term Care Ombudsman Program – Contact Information	
Call	1-888-229-2231 Calls to this number are free. Monday through Friday, 7:45 a.m. to 4:30 p.m.
Write	Executive Office on Aging Hawaii State Department of Health No. 1 Capitol District 250 South Hotel Street, Suite 406 Honolulu, Hawaii 96813-2831
Website	www.hi-ltc-ombudsman.org
EMAIL	info@hi-ltc-ombudsman.org

SECTION 7 Programs to help people pay for prescription drugs

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

Extra Help from Medicare

Because you're eligible for Medicaid, you qualify for and get Extra Help from Medicare to pay for your prescription drug plan costs. You don't need to do anything further to get this Extra Help.

If you have questions about Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048;
- The Social Security Office at 1-800-772-1213, between 8 am and 7 pm, Monday through Friday. TTY users call 1-800-325-0778; or
- Your State Medicaid Office at 808-524-3370 or 1-800-316-8005.

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

If you aren't sure what evidence to provide us, please contact a network pharmacy or Member Services. The evidence is often a letter from either the state Medicaid or Social Security office that confirms you are qualified for Extra Help. The evidence may also be state-issued documentation with your eligibility information associated with Home and Community-Based Services.

You or your appointed representative may need to provide the evidence to a network pharmacy when obtaining covered Part D prescriptions so that we may charge you the appropriate cost-sharing amount until the Centers for Medicare & Medicaid Services (CMS) updates its records to reflect your current status. Once CMS updates its records, you will no longer need to present the evidence to the pharmacy. Please provide your evidence in one of the following ways so we can forward it to CMS for updating:

- Write to Kaiser Permanente at:

  California Service Center
  Attn: Best Available Evidence
  P.O. Box 232407
  San Diego, CA 92193-2407
- Fax it to 1-877-528-8579.
- Take it to a network pharmacy.
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Member Services at 1-800-805-2739 (TTY users call 711) if you have questions.

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

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

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call the HIV Drug Assistance Program (HDAP) at 808-733-9360.

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this payment option, call Member Services at 1-800-805-2739 (TTY users call 711) or visit www.Medicare.gov.

Medicare Prescription Payment Plan – Contact Information	
Call	1-800-805-2739 Calls to this number are free. 7 days a week, 7:45 a.m. to 8 p.m. Member Services 1-800-805-2739 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. 7 days a week, 7:45 a.m. to 8 p.m.
Write	Kaiser Permanente Member Services 711 Kapiolani Blvd. Honolulu, HI 96813
Website	kp.org

SECTION 8 Railroad Retirement Board (RRB)

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

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press "0" to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press "1" to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren't free.
Website	https://RRB.gov

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 nothing or only your share of the cost for covered services.
- **Covered services** include all the medical care, health care services, supplies, equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

As a Medicare health plan, our plan must cover all services covered by Original Medicare.

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 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, 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** (see 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 that you have to pay the provider in full for services you get. Here are 4 exceptions:
  - Our plan covers emergency care or urgently needed services you get from an out-of-network provider. For more information, and to see what emergency or urgently needed services are, go to Section 3.
  - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network, if we or our Medical Group authorize the services before you get the care. In this situation, we'll cover these services as 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 care

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

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

You must choose a PCP within 30 days of enrolling in Kaiser Permanente or a PCP will be assigned to you. To choose your PCP, please call Member Services at 1-800-805-2739 (TTY 711), 7 days a week, 7:45 a.m. to 8 p.m. You can also make your selection at kp.org/finddoctors. Your PCP selection will be effective immediately.

How to change your PCP

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. To change your PCP, please call Member Services at 1-800-805-2739 (TTY 711), 7 days a week, 7:45 a.m. to 8 p.m. You can also make your selection at kp.org/finddoctors. Your PCP selection will be effective immediately.

When you call, tell us if you are seeing specialists or getting other covered services that need your PCP's approval (such as home health services and durable medical equipment) so we

can tell you if you need to get a referral from your new PCP to continue the services. Also, if there is a particular network specialist or hospital that you want to use, check with us to find out if your PCP makes referrals to that specialist or uses that hospital.

Please see your *Provider and Pharmacy 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, 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 1-800-805-2739 (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.
- If you visit the island of Hawaii (Big Island), you are encouraged to get your care at Kaiser Permanente medical facilities.

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 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. Don't return to the network specialist after your initial consultation visit unless we have authorized additional visits in your referral. Otherwise, the services may not be covered.

Prior authorization

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

- Services and items identified in Chapter 4 with a footnote (†).
- If your network provider decides that you require covered services not available from network providers, he or she will recommend to Medical Group that you be referred to an out-of-network provider inside or outside our service area. The appropriate Medical Group designee will authorize the services if he or she determines that the covered services are medically necessary and are not available from a network provider. Referrals to out-of-network providers will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. It specifies the duration of the referral without having to get additional approval from us. Please ask your network provider what services have been authorized if you are not certain. If the out-of-network specialist wants you to come back for more care, be sure to check if the referral covers the additional care. If it doesn't, please contact your network provider.
- After we are notified that you need post-stabilization care from an out-of-network provider following emergency care, we will discuss your condition with the out-of-network provider. If we decide that you require post-stabilization care and that this care would be covered if you received it from a network provider, we will authorize your care from the out-of-network provider only if we cannot arrange to have a

network provider (or other designated provider) provide the care. Please see Section 3.1 in this chapter for more information.

- Medically necessary transgender surgery and associated procedures.
- Care from a religious 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, Medical Group's regional transplant advisory committee or board (if one exists) will authorize the services if it determines that they are medically necessary or covered in accord with Medicare guidelines. In cases where no transplant committee or board exists, Medical Group will refer you to physician(s) at a transplant center, and Medical Group will authorize the services if the transplant center's physician(s) determine that they are medically necessary or covered in accord with Medicare guidelines.

When a specialist or another network provider leaves our plan

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

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. Prior authorization is required. Your network provider will need to get approval in advance from our plan or Medical Group.

- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 9).

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

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

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

SECTION 3 How to get 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 your 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 the United States or its territories.
- **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 will cover your follow-up post-stabilization care in accord with Medicare guidelines. It is very important that your provider call us to get authorization for post-stabilization care before you receive the care from the out-of-network provider. In most cases, you will only be held financially liable if you are notified by the out-of-network provider or us about your potential liability.

If your emergency care is provided by out-of-network providers, we'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 refer to your *Provider and Pharmacy Directory* for appointment and advice telephone numbers.

Our plan doesn't cover emergency services, urgently needed services, or any other services you get outside of the United States or its territories.

Section 3.3 Get care during a disaster

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

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

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

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

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

Section 4.1 If services aren't covered by our plan

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, 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.

Note: If a service isn't covered by our plan, it may be covered by Medicaid. Contact your state Medicaid agency for information about whether the service is covered under Medicaid and how to obtain the services.

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 that you're in a qualified clinical trial, you're only responsible for the in-network cost sharing for the services in that trial. If you paid more—for example, if you already paid the Original Medicare cost-sharing amount—we'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

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

covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

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

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

Section 5.2 Who pays for services in a clinical research study

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

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

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

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

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

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.

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

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies,* available at www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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's **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 12.

SECTION 7 Rules for ownership of durable medical equipment

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

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

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

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

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

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

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

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

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

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

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

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

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

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

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

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

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

- **Copayment:** the fixed amount you pay each time you 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.)

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

Note: Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum. If you're eligible for Medicare cost-sharing help under Medicaid, you're not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Medicare Advantage Plans have limits on the amount you have to pay out-of-pocket each year for medical services covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2026 the MOOP amount is $9,250**.

The amounts you pay for copayments and coinsurance for covered services count toward this maximum out-of-pocket amount. The amounts you pay for Part D drugs don't count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These services are marked with an asterisk (*) in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of **$9,250**, you won't have to pay any out-of-pocket costs for the rest of the year for 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, $15.00), you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
    - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
    - If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or urgently needed services outside the service area.)
- If you think a provider has balance billed you, call Member Services at 1-800-805-2739 (TTY users call 711).

We don't allow providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the

provider charges for a service. If you get a bill from a provider, call Member Services at 1-800-805-2739 (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 (Part D drug coverage is in Chapter 5). The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare-covered services must be provided according to 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 may not 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 that 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:

- You're covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost sharing for Medicare services. Medicaid also covers services Medicare doesn't cover.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you 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 2026, either Medicare or our plan will cover those services.
- This Kaiser Permanente Dual Complete plan is designed to provide better coordination of your benefits and care for people with both Medicare and Medicaid and will help you with all of your health care needs, including medications. For a summary of Medicaid benefits and cost-sharing, refer to the "Summary of Medicaid-Covered Benefits" at the end of the Medical Benefits Chart.
- If you're within our plan's 6-month period of deemed continued eligibility, we'll continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, you will need to consult with Medicaid to find out what if anything Medicaid will cover for services not covered by our plan but covered by Medicaid. Also, the cost sharing for Part D drugs you pay us may change. The amount you pay for Medicare-covered services may increase during this period. Contact the State of Hawaii's Department of Human Services Med-QUEST Division (Medicaid) at 1-800-316-8005 (TTY 711) for more information about your Medicaid coverage during this period.

If you're eligible for Medicare cost-sharing help under Medicaid, you don't pay anything for the services listed in the Medical Benefits Chart, as long as you meet the coverage requirements described above.

 This apple shows the preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.	**$0** **If you lose your Medicaid coverage**, you pay **$20** per visit.

† Your provider must obtain prior authorization from our plan.
* Cost-sharing for these services or items doesn't apply to the maximum out-of-pocket amount.
** In addition to the copayment listed, you will be responsible for any amount above that which is the difference between the HDS allowed amount for that treatment and the amount your dentist charges.

Covered Service	What you pay
Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Ambulance services Covered ambulance services, whether for an emergency or †non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should	**$0** **If you lose your Medicaid coverage**, you pay **$400** per one-way trip.

† Your provider must obtain prior authorization from our plan.
* Cost-sharing for these services or items doesn't apply to the maximum out-of-pocket amount.
** In addition to the copayment listed, you will be responsible for any amount above that which is the difference between the HDS allowed amount for that treatment and the amount your dentist charges.

Covered Service	What you pay
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.	
Annual routine physical exam Routine physical exams are covered if the exam is medically appropriate preventive care in accord with generally accepted professional standards of practice.	There is no coinsurance, copayment, or deductible for this preventive care.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following 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.

† Your provider must obtain prior authorization from our plan.
* Cost-sharing for these services or items doesn't apply to the maximum out-of-pocket amount.
** In addition to the copayment listed, you will be responsible for any amount above that which is the difference between the HDS allowed amount for that treatment and the amount your dentist charges.

Covered Service	What you pay
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**$0** **If you lose your Medicaid coverage**, you pay **$30** per visit.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.

† Your provider must obtain prior authorization from our plan.
* Cost-sharing for these services or items doesn't apply to the maximum out-of-pocket amount.
** In addition to the copayment listed, you will be responsible for any amount above that which is the difference between the HDS allowed amount for that treatment and the amount your dentist charges.

Covered Service	What you pay
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation ○ These Medicare-covered services are provided by a network chiropractor. For the list of network chiropractors, please visit http://www.ashlink.com/ASH/KaiserHIC and click the "Medicare Provider Search" link for Medicare members.	**$0** **If you lose your Medicaid coverage**, you pay **$15** per visit.
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	Cost sharing for this service will vary depending on individual services provided under the course of treatment. **$0** **If you lose your Medicaid coverage**, you pay **$40** per primary care visit and **$55** per specialty care visit.

† Your provider must obtain prior authorization from our plan.
* Cost-sharing for these services or items doesn't apply to the maximum out-of-pocket amount.
** In addition to the copayment listed, you will be responsible for any amount above that which is the difference between the HDS allowed amount for that treatment and the amount your dentist charges.

Covered Service	What you pay
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and you pay **$0**.

† Your provider must obtain prior authorization from our plan.
* Cost-sharing for these services or items doesn't apply to the maximum out-of-pocket amount.
** In addition to the copayment listed, you will be responsible for any amount above that which is the difference between the HDS allowed amount for that treatment and the amount your dentist charges.

Covered Service	What you pay
• Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
• Procedures performed during a screening colonoscopy (for example, removal of polyps). **Note:** All other colonoscopies are subject to the applicable cost-sharing listed elsewhere in this chart.	**$0**
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation	**$0** **If you lose your Medicaid coverage**, you pay **$55** per visit.

† Your provider must obtain prior authorization from our plan.
* Cost-sharing for these services or items doesn't apply to the maximum out-of-pocket amount.
** In addition to the copayment listed, you will be responsible for any amount above that which is the difference between the HDS allowed amount for that treatment and the amount your dentist charges.

Covered Service	What you pay
treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover certain preventive and comprehensive dental services (anesthesia, consultation, and minor pain relief) through our agreement with Hawaii Dental Service (HDS). HDS provides preventive and comprehensive dental care listed below through a network of dentists that contract with HDS to provide dental services. Coverage is based on the **"HDS allowed amount,"** which is the amount the participating dentist agrees to accept for services that are covered benefits. You pay the percentage of the HDS allowed amount (specified below for each covered service) when you receive a service from an HDS Medicare Advantage network dentist. Note: If you receive services from a dentist that doesn't participate in the HDS Medicare Advantage network, the services are not covered by our plan (except in an emergency) and you will be responsible for the full cost of the services unless otherwise specified by state or federal law. Hawaii general excise tax imposed or incurred in connection with any fees charged, whether or not passed on to a patient by a dentist is not covered by our plan and you will be responsible. If services for a listed procedure are performed by an HDS Medicare Advantage network dentist, you will pay the specified cost-sharing, subject to the limitations and exclusions stated in HDS's processing guidelines. Claims are processed in accordance with the processing guidelines in effect at the time a claim is processed.	

† Your provider must obtain prior authorization from our plan.
* Cost-sharing for these services or items doesn't apply to the maximum out-of-pocket amount.
** In addition to the copayment listed, you will be responsible for any amount above that which is the difference between the HDS allowed amount for that treatment and the amount your dentist charges.

Covered Service	What you pay
When a dental condition has multiple professionally accepted treatments, HDS will determine the least costly professionally accepted treatment as the benefit and consider the alternative methods of treatment. This determination is not intended to reflect negatively on the dentist's treatment plan or to recommend which treatment should be provided. It is a determination of benefits under the terms of your HDS plan coverage. You and your dentist should decide on the course of treatment. **Your patient share is based on the least expensive professionally accepted treatment as determined by HDS and the difference between the HDS allowed amount for that treatment and the amount your dentist charges.** The American Dental Association may periodically update Current Dental Terminology (CDT) procedure codes and nomenclature or descriptors shown in the chart. Such updates may be used to describe these covered procedures in compliance with federal legislation. For more information on about your dental benefits, or a list of participating dentists, please visit HDS's website at hawaiidentalservice.com or call HDS customer service at 808-529-9248 (or toll free at 1-844-379-4325) Monday through Friday, 7:30 a.m. to 4:30 p.m. Dental services covered out-of-state are only covered when provided by Delta Dental Medicare Advantage network dentists. Coverage, limitations, and exclusions are subject to the same HDS terms and conditions. To locate a Delta Dental Medicare	

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Covered Service	What you pay
Advantage network dentist, contact the State's local Delta Dental office.	
Preventive and diagnostic services* **Teeth cleaning — Two total cleanings per calendar year:** • D1110: Prophylaxis (teeth cleaning).	**$0**
• D4355: Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis on a subsequent visit (applied to the patient's annual teeth cleaning benefit).	**$0**
• D4346: Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation (applied to the patient's annual teeth cleaning benefit).	**$0**
Fluoride • D1206: Topical application of fluoride varnish twice per calendar year (combined frequency limitation with D1208).	**$0**
• D1208: Topical application of fluoride twice per calendar year (combined frequency limitation with D1206).	**$0**
• D1354: Interim caries arresting medicament application twice per tooth per 12-month time period and six teeth per date of service.	**$0**

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Covered Service	What you pay
Examinations — Twice per calendar year (unless otherwise noted): • D0120: Periodic oral evaluation – established patient.	**$0**
• D0140: Limited oral evaluation – problem focused (not applied to the patient's annual exam benefit) - once per patient per dentist/dental office, per 12-month period	**$0**
• D0150: Comprehensive oral evaluation – new or established patient.	**$0**
• D0160: Detailed and extensive oral evaluation – problem focused, by report.	**$0****
• D0170: Re-evaluation – limited, problem focused (established patient; not post-operative visit).	**$0****
• D0180: Comprehensive periodontal evaluation – new or established patient.	**$0**
Bitewing X-rays — once per calendar year: • D0270: Bitewing – single radiographic image.	**$0**
• D0272: Bitewings – two radiographic images.	**$0**
• D0273: Bitewings – three radiographic images.	**$0**
• D0274: Bitewings – four radiographic images.	**$0**
• D0277: Vertical bitewings – 7 to 8 radiographic images.	**$0**

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Covered Service	What you pay
Other X-rays†: Any combination of periapical, occlusal, bitewing, and/or panoramic images taken by the same dentist/dental office on the same date of service are processed as a complete series (D0210) when the total fees equal or exceed the fee for a complete series (D0210).	
• D0210: Intraoral – complete series of radiographic images (Full Mouth X-rays) – limited to once every 5 years.	**$0**
• D0220: Intraoral – periapical first radiographic image.	**$0**
• D0230: Intraoral – periapical each additional radiographic image.	**$0**
• D0240: Intraoral – occlusal radiographic image.	**$0**
• D0250: Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector.	**$0**
• D0330: Panoramic radiographic image – counts toward D0210 frequency and limited to once every 5 years.	**$0**
• D0372: Intraoral tomosynthesis - comprehensive series of radiographic images.	**$0****
• D0373: Intraoral tomosynthesis - bitewing radiographic image.	**$0****
• D0374: Intraoral tomosynthesis - periapical radiographic image.	**$0****
• D0419: Assessment of salivary flow by measurement.	**$0**

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Covered Service	What you pay
• D0460: Pulp vitality tests.	**$0**
• D0472: Accession of tissue, gross examination, preparation and transmission of written report.	**$0**
• D0473: Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	**$0**
• D0474: Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	**$0**
• D0480: Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report.	**$0**
• D0484: Consultation on slides prepared elsewhere.	**$0**
• D0485: Consultation, including preparation of slides from biopsy material supplied by referring source.	**$0****
Adjunctive general services (anesthesia, consultation, and minor pain relief)†*	
• D2799: Interim crown - further treatment or completion of diagnosis necessary prior to final impression.	**$0**
• D2940: Placement of interim direct restoration – limited to once every 2 years.	**$0**
• D9110: Palliative (emergency) treatment of dental pain – minor procedure.	**$0**
• D9222: Deep sedation/general anesthesia – first 15 minutes, or any portion thereof.	**$0**

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Covered Service	What you pay
• D9223: Deep sedation/general anesthesia – each subsequent 15 minutes increment, or any portion thereof.	**$0**
• D9239: Intravenous moderate (conscious) sedation/analgesia – first 15 minutes, or any portion thereof.	**$0**
• D9243: Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minutes increment, or any portion thereof.	**$0**
• D9310: Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician.	**$0**
• D9430: Office visit for observation (during regularly scheduled hours) – no other services performed.	**$0**
• D9440: Office visit – after regularly scheduled hours.	**$0**
• D9930: Treatment of complications (post-surgical) – unusual circumstances, by report.	**$0**
• D9944 Occlusal guard - hard appliance, full arch – limited to one guard every 5 years.	**$0**
• D9945 Occlusal guard - soft appliance, full arch – limited to one guard every 5 years.	**$0**
• D9946 Occlusal guard - hard appliance, partial arch – limited to one guard every 5 years.	**$0**
• D9999: Unspecified adjunctive procedure, by report.	**$0**

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Covered Service	What you pay
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • †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	**$0** **If you lose your Medicaid coverage**, you pay **20% coinsurance**.

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Covered Service	What you pay
pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.	
• Diabetes self-management training is covered under certain conditions.	**$0**
Durable medical equipment (DME) and related supplies† (For a definition of durable medical equipment, go to Chapter 12 and Chapter 3) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at kp.org/directory. In addition, we cover the following DME item not covered by Medicare: • Ultraviolet light therapy equipment for the following conditions: Cutaneous lymphoma, lichen planus, scleroderma, vitiligo, eczema (atopic dermatitis, idiopathic dermatitis), pruritus, prurigo nodularis, granuloma annulare, lymphomatoid papulosis, pityriasis lichenoides, and graft versus host diseases.	**$0** **If you lose your Medicaid coverage**, you pay **20% coinsurance**, except you pay **$0** for ultraviolet light therapy equipment for psoriasis treatment. **Oxygen equipment** Your cost sharing for Medicare oxygen equipment coverage is **$0**, every time you receive equipment. **If you lose your Medicaid coverage**, you pay **20% coinsurance**. Your cost sharing won't change after you're enrolled for 36 months.

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Covered Service	What you pay
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. **You have emergency care coverage inside the United States and its territories.**	**$0** **If you lose your Medicaid coverage**, you pay **$115** per visit. This copayment does not apply if you are admitted directly to the hospital within 24 hours as an inpatient (it does apply if you are admitted to the hospital as an outpatient; for example, if you are admitted for observation). †If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost sharing you would pay at a network hospital.
Fitness benefit (One Pass™)* A fitness benefit is provided through the One Pass program to help members take control of their health and feel their best. The One Pass program includes: • Gyms and Fitness Locations: You receive a membership with access to a wide variety of in-network gyms through the core and premium network. Fitness locations include national, local,	**$0**

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Covered Service	What you pay
and community fitness centers and boutique studios. You can use any in-network location, and you may use multiple participating fitness locations during the same month. Participating gyms and fitness centers may vary by location and are subject to change. • Online Fitness: You have access to live, digital fitness classes and on-demand workouts through the One Pass member website or mobile app. • Fitness and Social Activities: You also have access to groups, clubs, and social events through the One Pass member website. • Home Fitness Kits: If you prefer to work out at home, you can also select one home fitness kit per calendar year for Strength, Yoga, or Dance. Kits are subject to change and once selected cannot be exchanged. • Brain Health: Access to online brain health cognitive training programs. For more information about participating gyms and fitness locations, the program's benefits, or to set up your online account, please visit www.YourOnePass.com or call 1-877-614-0618 (TTY 711), Monday through Friday, 3 a.m. to 4 p.m., HST. The following are not covered: Additional services (such as personal training, fee-based group fitness classes, expanded access hours, or additional classes outside of the standard membership offering). One Pass® is a registered trademark of Optum, Inc. in the U.S. and other jurisdictions and is a voluntary program. The One Pass program and amenities vary by plan, area, and location. The information provided	

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Covered Service	What you pay
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.	
Health and wellness education programs As part of our Healthy Lifestyle Programs, our plan covers a number of group health education classes including: Aging with Grace, Bone Health for Older Adults, Senior Summit Balance and Fitness Testing, Senior Summit Seminars, and the Senior Wellness groups. The Healthy Lifestyle Programs are provided by health educators, lifestyle coaches, or other qualified health professionals. For more information about our health education programs, please call Member Services or go to our website at kp.org/classes.	**$0**
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	**$0** **If you lose your Medicaid coverage**, you pay **$40** per visit.

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Covered Service	What you pay
HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months. If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy.	There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	**$0** **Note:** There is no cost-sharing for home health care services and items provided in accord with Medicare guidelines. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply if the item is covered under a different benefit; for example, durable medical equipment not provided by a home health agency.

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Covered Service	What you pay
Home infusion therapy† Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	**$0** for professional services, training, and monitoring. **Note:** The components (such as, Medicare Part B drugs, DME, and medical supplies) needed to perform home infusion may be subject to the applicable cost-sharing listed elsewhere in this Medical Benefits Chart depending on the item.
We cover home infusion supplies and drugs if all of the following are true: • Your prescription drug is on our Medicare Part D formulary • We approved your prescription drug for home infusion therapy • Your prescription is written by a network provider and filled at a network home infusion pharmacy	**$0** **Note:** If a covered home infusion supply or drug is not filled by a network home-infusion pharmacy, the supply or drug may be subject to the applicable cost-sharing listed elsewhere in this document depending on the service.
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A

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Covered Service	What you pay
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. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. ***For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services	and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan.

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Covered Service	What you pay
depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • *If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare **For services covered by our plan but not covered by Medicare Part A or B:** We will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **For drugs that may be covered by our plan's Part D benefit:** If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.3). **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.	
Our plan covers hospice consultation services for a terminally ill person who hasn't elected the hospice benefit.	**$0**

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** In addition to the copayment listed, you will be responsible for any amount above that which is the difference between the HDS allowed amount for that treatment and the amount your dentist charges.

Covered Service	What you pay
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 7 for more information.	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. There is no limit to the number of medically necessary hospital days or services that are generally and customarily provided by acute care general hospitals. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary)	**$0** **If you lose your Medicaid coverage**, cost-sharing is charged for each inpatient stay. You pay **$405** per day for days 1–6 and **$70** per day for days 7–30. 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.

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** In addition to the copayment listed, you will be responsible for any amount above that which is the difference between the HDS allowed amount for that treatment and the amount your dentist charges.

Covered Service	What you pay
• Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • †Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If we provide transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate	†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.

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** In addition to the copayment listed, you will be responsible for any amount above that which is the difference between the HDS allowed amount for that treatment and the amount your dentist charges.

Covered Service	What you pay
lodging and transportation costs for you and a companion. • Blood - including storage and administration • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay.	**$0** **If you lose your Medicaid coverage**, cost-sharing is charged for each inpatient stay. You pay **$340** per day for days 1–6 and **$15** per day for days 7–90. 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.

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** In addition to the copayment listed, you will be responsible for any amount above that which is the difference between the HDS allowed amount for that treatment and the amount your dentist charges.

Covered Service	What you pay
	†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.
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay If you've used up your 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: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • †Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • †Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including	**$0** **If you lose your Medicaid coverage**, and your inpatient or SNF stay is no longer covered, we will continue to cover Medicare Part B services at the applicable cost-sharing listed elsewhere in this Medical Benefits Chart when provided by network providers.

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Covered Service	What you pay
adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) **MDPP services are covered for eligible people under all Medicare health plans.** MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.

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** In addition to the copayment listed, you will be responsible for any amount above that which is the difference between the HDS allowed amount for that treatment and the amount your dentist charges.

Covered Service	What you pay
Medicare Part B drugs **These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:** • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi® (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them	**Administered Part B drugs** **$0**. **If you lose your Medicaid coverage,** you pay **20% coinsurance** for Medicare Part B drugs when administration or observation by medical personnel is required and the drugs are administered to you by a network provider. Some drugs may be less than 20% if those drugs are determined to exceed the amount of inflation. **Part B drugs from a network pharmacy** **$0** for up to a 30-day supply of Medicare Part B drugs on our formulary when obtained from a **network pharmacy**.

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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 • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics	

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Covered Service	What you pay
• 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) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) We also cover some vaccines under Part B and most adult vaccines under our Part D drug benefit. Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6.	
Nursing hotline 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. They can often answer questions about a minor concern, tell you what to do if a network facility is closed, or advise you about what to do next, including making a same-day urgent care appointment for you if it's medically appropriate. To speak with an advice nurse 24 hours a day, 7 days a week or make an appointment, please refer to your	**$0**

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Covered Service	What you pay
Provider and Pharmacy Directory for appointment and advice telephone numbers.	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable)	**$0** **If you lose your Medicaid coverage**, you pay **20% coinsurance** for clinically administered Medicare Part B drugs 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 • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	**$0**

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Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to: • X-rays	**$0** **If you lose your Medicaid coverage**, you pay **$30** per X-ray.
• Radiation (radium and isotope) therapy including technician materials and supplies	**$0** **If you lose your Medicaid coverage**, you pay **$85** per visit.
• Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Blood - including storage and administration	**$0**
• Lab tests	**$0** **If you lose your Medicaid coverage**, you pay **$30** per day.
• Diagnostic non-laboratory tests such as electrocardiograms (EKGs), electroencephalograms (EEGs), cardiovascular stress tests, and pulmonary function tests when your doctor or other health care provider orders them to treat a medical problem.	**$0** **If you lose your Medicaid coverage**, you pay **$30** per test.
• Diagnostic non-laboratory tests such as CT scans, MRIs, and PET scans when your doctor or other health care provider orders them to treat a medical problem.	**$0** **If you lose your Medicaid coverage**, you pay **$240** per test.

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Covered Service	What you pay
• Ultrasounds	**$0** **If you lose your Medicaid coverage**, you pay **$30** per ultrasound.
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at www.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.	**$0**

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Covered Service	What you pay
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	**$0** **If you lose your Medicaid coverage**, you pay **$115** per Emergency Department visit and **$300** per outpatient surgery visit. Refer to the "Outpatient hospital observation" section of this Medical Benefits Chart for the cost-sharing applicable to observation services.
• Laboratory and diagnostic tests billed by the hospital	**$0** **If you lose your Medicaid coverage**, you pay **$30** per day for lab tests and **$30** per diagnostic test.
• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it	**$0** **If you lose your Medicaid coverage**, you pay **$105** per day for partial hospitalization.
• X-rays and other radiology services billed by the hospital	**$0** **If you lose your Medicaid coverage**, you pay **$30** per X-ray or ultrasound, or **$240** per test for CT, PET, or MRI.
• Medical supplies such as splints and casts	**$0**

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** In addition to the copayment listed, you will be responsible for any amount above that which is the difference between the HDS allowed amount for that treatment and the amount your dentist charges.

Covered Service	What you pay
• Certain drugs and biologicals you can't give yourself **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.	**$0** **If you lose your Medicaid coverage**, you pay **20% coinsurance**. Some drugs may be less than 20% if those drugs are determined to exceed the amount of inflation.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**$0** **If you lose your Medicaid coverage**, you pay **$50** per individual visit and **$40** per group visit.
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**$0** **If you lose your Medicaid coverage**, you pay **$35** per visit.

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Covered Service	What you pay
Outpatient substance use disorder services We provide treatment and counseling services to diagnose and treat substance abuse (including individual and group therapy visits).	**$0** **If you lose your Medicaid coverage**, you pay **$50** per individual visit and **$40** per group visit.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	**$0** **If you lose your Medicaid coverage**, you pay **$300** per visit.
Partial hospitalization services and intensive outpatient services *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. **Note**: Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.	**$0** **If you lose your Medicaid coverage**, you pay **$105** per day.

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Covered Service	What you pay
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** **If you lose your Medicaid coverage**, you pay **$50** per individual visit and **$40** per group visit.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your network provider, if your doctor orders it to see if you need medical treatment • Second opinion by another network provider prior to surgery	**$0** **If you lose your Medicaid coverage**, you pay **$40** per primary care visit and **$55** per specialty care visit.
• Certain telehealth services, including: primary and specialty care, which includes inpatient hospital services, skilled nursing facility (SNF) services, cardiac rehabilitation services, emergency services, urgently needed services, intensive outpatient program services, home health services, occupational therapy services, mental health, podiatry, psychiatric services, physical therapy and	**$0**

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Covered Service	What you pay
speech-language pathology services, X-ray services, outpatient hospital services, observation services, outpatient substance abuse, 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 o You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. We offer the following means of telehealth: o Interactive video visits for professional services when care can be provided in this format as determined by a network provider o Scheduled telephone appointment visits for professional services when care can be provided in this format as determined by a network provider • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location	

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Covered Service	What you pay

• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location
• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:
  ○ You have an in-person visit within 6 months prior to your first telehealth visit
  ○ You have an in-person visit every 12 months while getting these telehealth services
  ○ Exceptions can be made to the above for certain circumstances
• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**:
  ○ You're not a new patient **and**
  ○ The check-in isn't related to an office visit in the past 7 days **and**
  ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:
  ○ You're not a new patient **and**
  ○ The evaluation isn't related to an office visit in the past 7 days **and**
  ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment	

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Covered Service	What you pay
• Consultation your doctor has with other doctors by phone, internet, or electronic health record	
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	**$0** **If you lose your Medicaid coverage**, you pay **$55** per office visit and **$300** per outpatient surgery.
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we covers pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. A one-time hepatitis B virus screening.	There is no coinsurance, copayment, or deductible for the PrEP benefit.

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Covered Service	What you pay
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual digital rectal exam or PSA test.
Prosthetic and orthotic devices and related supplies† Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this table for more detail.	**$0** **If you lose your Medicaid coverage**, you pay **20% coinsurance** for external prosthetic or orthotic devices and supplies (including wound care supplies), except you pay **$0** for surgically implanted internal devices.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**$0** **If you lose your Medicaid coverage**, you pay **$25** per visit.

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Covered Service	What you pay
Residential chemical dependency services A member may receive residential services in a specialized alcohol or chemical dependence treatment unit or facility approved in writing by Medical Group. All covered chemical dependency services will be provided under an approved individualized treatment plan for a specified period of time.	**$0** **If you lose your Medicaid coverage**, you pay **$340** per day for days 1–6 of a stay. Thereafter, you pay **$0** for the remainder of your covered stay.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months. **Eligible members are** people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

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Covered Service	What you pay
for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.

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Covered Service	What you pay
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 people 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. 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	**$0** **If you lose your Medicaid coverage**, you pay **$40** per visit.
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible)	**$0** **If you lose your Medicaid coverage**, you pay **20% coinsurance**.

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Covered Service	What you pay
• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • †Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	**$0**
• Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care) 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.	**$0** No additional charge for services received during a hospital stay. If you lose your Medicaid coverage, refer to the "Inpatient hospital care" section of this Medical Benefits Chart for the cost-sharing applicable to inpatient stays.
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) We cover up to 100 days per benefit period of skilled inpatient services in a network skilled nursing facility in accord with Medicare guidelines (a prior hospital stay is not required). Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets	**$0** **If you lose your Medicaid coverage**, you pay the following per benefit period: • **$0** for days 1–20 • **$218** per day for days 21–40 • **$0** for days 41–100 A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't received any

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Covered Service	What you pay
• Skilled nursing services • Physical therapy, occupational therapy and speech therapy • Drugs administered to you as part of our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	inpatient hospital care or skilled care in a SNF for 60 days in a row. **Note:** If a benefit period begins in 2025 for you and does not end until sometime in 2026, the 2025 cost-sharing will continue until the benefit period ends.

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Covered Service	What you pay
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office	**$0** **If you lose your Medicaid coverage**, you pay **$20** per visit.

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Covered Service	What you pay
• Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. • **Inside our service area:** You must obtain urgent care from network providers, unless our provider network is temporarily unavailable or inaccessible due to an unusual and	**$0** **If you lose your Medicaid coverage**, you pay **$40** per urgent care visit or **$115** per Emergency Department visit.

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** In addition to the copayment listed, you will be responsible for any amount above that which is the difference between the HDS allowed amount for that treatment and the amount your dentist charges.

Covered Service	What you pay
extraordinary circumstance (for example, major disaster). • **Outside our service area:** You have urgent care coverage within the United States and its territories when you travel if you need medical attention right away for an unforeseen illness or injury and you reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our service area. **See Chapter 3, Section 3, for more information.**	
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. • Visual field tests.	**$0** **If you lose your Medicaid coverage**, you pay **$40** per visit.
• For people with diabetes, screening for and monitoring of diabetic retinopathy. • 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.	**$0**

† Your provider must obtain prior authorization from our plan.
* Cost-sharing for these services or items doesn't apply to the maximum out-of-pocket amount.
** In addition to the copayment listed, you will be responsible for any amount above that which is the difference between the HDS allowed amount for that treatment and the amount your dentist charges.

Covered Service	What you pay
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. • Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	**$0*** for eyewear in accord with Medicare guidelines. **If you lose your Medicaid coverage**, you pay **20% coinsurance***. ***Note:** If the eyewear you purchase costs more than what Medicare covers, you pay the difference.
Welcome to Medicare preventive visit Our plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit.	There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit. **Note: If you lose your Medicaid coverage**, see "Outpatient diagnostic tests and therapeutic services and supplies" earlier in this chart for cost sharing associated with EKGs.
Note: Refer to Chapter 1, Section 7, and Chapter 11 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 maximum out-of-pocket amount.
** In addition to the copayment listed, you will be responsible for any amount above that which is the difference between the HDS allowed amount for that treatment and the amount your dentist charges.

Summary of Medicaid-Covered Benefits

The benefits described below are covered by Medicaid. The benefits described earlier in this chart are covered by Medicare. For each benefit listed below, you can see what Medicaid covers and what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility. For more information about Medicaid benefits, please refer to your Kaiser Permanente QUEST Member Handbook.

Benefit	Medicaid State Plan	Kaiser Permanente Dual Complete
Dialysis	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.
Durable medical equipment and medical supplies, including prosthetics and orthotics	$0 copay for Medicaid-covered services. Prior approval is required	$0 copay for Medicare-covered supplies.
Emergency and post stabilization services	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.
Family planning services	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.
Habilitation services (Audiology services, occupational therapy, physical therapy, speech-language therapy, vision services, augmentative communication devices, reading devices, visual aids)	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services. Augmentative communication devices, reading devices, and visual aids are not covered.
Home health services	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.
Non-emergency transportation services	$0 copay for Medicaid-covered services. Prior approval is required.	Not covered.

Benefit	Medicaid State Plan	Kaiser Permanente Dual Complete
Nutrition counseling	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered medical nutrition therapy services.
Outpatient hospital services	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.
Physician services	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.
Pregnancy-related services	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.
Prescription drugs	$0 copay for Medicaid-covered services.	Medicare Part B drugs: $0 copay. Medicare Part D drugs: 0-25%
Preventive services	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.
Radiology, laboratory, and other diagnostic services	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.
Rehabilitation services	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.
Smoking cessation services	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.
Telehealth services	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.
Urgent care services	$0 copay for Medicaid-covered services. Urgent care out of area is not covered for members over age 21.	$0 copay for Medicare-covered services.
Vision and hearing services	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.
Acute inpatient hospital for behavioral health services	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.

Benefit	Medicaid State Plan	Kaiser Permanente Dual Complete
Ambulatory mental health services	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.
Services from qualified professional like psychiatrists, psychologists, counselors, social workers, registered nurses, and others	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.
Substance abuse treatment programs	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.
Prescribed drugs, including medication management and patient counseling	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.
Psychiatric or psychological evaluation	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.
Skilled nursing facility	$0 copay for Medicaid-covered services.	$0 copay for Medicare-covered services.
Home- and community-based services including*: (chore, adult day health, personal care, adult day care, personal emergency response system, skilled nursing, residential care like Community Care Foster Family Home or Expanded Adult Residential Care Home) *Individual needs to be qualified for Long-Term Services and Support	$0 copay for Medicaid-covered services.	Not covered.

Benefit	Medicaid State Plan	Kaiser Permanente Dual Complete
Basic dental benefit	Covered by **Department of Human Services** (DHS) Med-QUEST. Prevention and control of oral diseases are covered, including cleanings and dental procedures such as X-rays and fillings. Coverage also includes restoration of chewing functions which, based on the individual case, may include root canals, crowns, and/or dentures. To find a dentist who accepts Medicaid, call the Community Case Management Corp (CCMC) at 808-792-1070 or toll-free at 1-888-792-1070. CCMC can explain the covered dental benefits and help you find a dentist near you.	$0 Covered preventive dental services listed below are provided by Hawaii Dental Service (HDS) Medicare Advantage Network: • Two preventive oral exams and teeth cleanings per calendar year • One bite-wing X-ray per calendar year • One full-mouth X-ray every 5 years† • Two fluoride applications per calendar year • Adjunctive general services: anesthesia, consultation, and minor pain relief (including one occlusal guard every 5 years)† For the list of HDS Medicare Advantage Network dentists, visit hawaiidentalservice.com, or call HDS customer service at 1-844-379-4325 (Monday through Friday, 7:30 a.m. to 4:30 p.m.). Note: Dental services covered out-of-state are only covered when provided by Delta Dental Medicare Advantage network dentists. Coverage, limitations, and exclusions are subject to the same HDS terms and conditions. To locate a Delta Dental Medicare Advantage

Benefit	Medicaid State Plan	Kaiser Permanente Dual Complete
		network dentist, contact the State's local Delta Dental office.
Behavioral health services for adults enrollees with serious mental illness (SMI)	Services are covered by Community Care Services (CCS).	Not covered.

SECTION 3 Services covered outside of our plan

The following services aren't covered by our plan but are available through Medicaid:

- Transportation to get medical care.
- Vision services (routine eye exams once in 24 months and one pair of glasses every 24 months).
- Hearing services.
- Home and community based services (i.e. adult day health).

Note: This is not a complete list. Please contact your state Medicaid agency for complete details about what is and is not covered by your Medicaid plan, including the type of plan (for example, fee-for-service or managed care plan). Also, if you get Medicaid-covered services from a network provider that are not covered by our plan, you will need to show your Medicaid card when you get the services.

SECTION 4 Services that aren't covered by our plan (exclusions)

This section tells you what services are excluded.

The chart below lists services and items that aren't covered by our plan under any conditions or are covered by our plan 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 will not pay for them. The only exception is if the service is appealed and decided: upon appeal to be a medical service that we should have paid for or covered because of your specific situation.

(For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 6.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances
Care in an intermediate or residential care facility, assisted living facility, or adult foster home	Covered as described in "Residential chemical dependency services" section of the Medical Benefits Chart
Conception by artificial means, such as in vitro fertilization, zygote intrafallopian transfers, ovum transplants, and gamete intrafallopian transfers (except artificial insemination and related services covered by Medicare)	Not covered under any condition
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance
Custodial care Custodial care is personal care that 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 under Original Medicare.

Services not covered by Medicare	Covered only under specific conditions
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (Go to Chapter 3, Section 5 for more information on clinical research studies)
Eyeglasses and contact lenses	One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens.
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Hearing aids or exams to fit hearing aids	This exclusion doesn't apply to cochlear implants and osseointegrated external hearing devices covered by Medicare.
Home-delivered meals	Not covered under any condition
Homemaker services include basic household help, including light housekeeping or light meal preparation.	Not covered under any condition
Massage therapy	Not covered under any condition
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

Services not covered by Medicare	Covered only under specific conditions
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Physical exams and other services (1) required for obtaining or maintaining employment or participation in employee programs, (2) required for insurance or licensing, or (3) on court order or required for parole or probation	Covered if a network physician determines that the services are medically necessary or medically appropriate preventive care.
Private duty nursing	Not covered under any condition
Private room in a hospital	Covered only when medically necessary
Psychological testing for ability, aptitude, intelligence, or interest	Not covered under any condition
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 eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids	One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens.

Services not covered by Medicare	Covered only under specific conditions
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.	Not covered under any condition
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 that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the member's condition does not require that the services be provided by a licensed health care provider	Not covered under any condition
Services related to noncovered services or items	When a service or item is not covered, all services related to the noncovered service or item are excluded, (1) except for services or items we would otherwise cover to treat complications of the noncovered service or item, or (2) unless covered in accord with Medicare guidelines.
Services to reverse voluntary, surgically induced infertility	Not covered under any condition
Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a network provider	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
Travel and lodging expenses	We may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines.

SECTION 5 Hawaii Dental Service dental exclusions and limitations

Exclusions

The following are exclusions and are not payable by the HDS Plan:

- Services that are not included as a benefit in the Medical Benefits Chart;
- Services that are not covered procedure codes in the HDS Procedure Code Guidelines;
- Services to correct or alleviate congenital malformations including, but not limited to, cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis, and anodontia;
- Services to correct occlusion and services other than those for the replacement of structure loss from caries that are necessary to alter, restore, or maintain occlusion including, but not limited to, increasing vertical dimension, equilibration, periodontal splinting, orthodontic splinting, other splinting, restoration of tooth structure lost from attrition, abrasion, abfraction or temporomandibular joint ("TMJ"), restoration for tooth malalignment, gnathological recording, and treatment of disturbances of the temporomandibular joint;
- Charges for hospitalization including an emergency room visit;
- Services to correct or cure injuries or conditions covered under workers' compensation or other employer liability laws;
- Cosmetic services including, but not limited to, cosmetic surgery, enamel hypoplasia, fluorosis, and anodontia;
- Teeth whitening, except for specific circumstances related to endodontic tooth discoloration and/or clinical determination tooth is dead;
- Ambulance services and any other means of transport;
- Services payable by a governmental entity, the member's medical plan, or by another party; and
- All taxes imposed on services received by a member.

Coverage Limitations

- A service must be clinically necessary, rendered within the professional standard of care, and a covered benefit to be payable by the HDS Plan. Diagnostic and preventive

services rendered within the professional standard of care are included as clinically necessary. A service that is covered benefit but is not clinically necessary or does not meet the professional standard of care is not payable by the HDS Plan.

- If the HDS Plan has a plan maximum, then the total HDS share payable by HDS for a member will not exceed the plan maximum. However, if the HDS Plan has a diagnostic and preventive waiver, then the HDS share for diagnostic and preventive services does not apply to the plan maximum. Costs for services that exceed the plan maximum are not payable by the HDS Plan.
- If the HDS Plan has a maximum out of pocket, then the HDS Plan will pay for covered benefits at an HDS copayment percentage of 100% when the patient share exceeds the maximum out of pocket. For purposes of calculating the maximum out of pocket, the patient share does not include payments made for non-covered services, the difference between the submitted amount and the allowed amount for alternate benefits, and the difference between the submitted amount and the allowed amount for services received from non-participating dentists.
- If a benefit category has a maximum, then the total HDS share payable by HDS for services within the benefit category for a member will not exceed the maximum. Costs for services in the benefit category that exceed the maximum are not payable by the HDS Plan.
- If the HDS Plan has a deductible on a service, then the service is not payable by the HDS Plan until the deductible is met.
- If the HDS Plan has a waiting period on a service, then the service is not payable by the HDS Plan until the member is enrolled continuously for the waiting period.
- A service that has an age limitation that is performed on a member who does not meet the age limitation is not payable by the HDS Plan.
- A service that exceeds frequency limitations is not payable by the HDS Plan regardless of the previous services being paid by another plan.
- A service that does not meet the criteria stated in the HDS procedure code guidelines is not payable by the HDS Plan.
- A service performed by two or more dentists under a single treatment plan is payable by the HDS Plan to only one dentist.
- A member must notify the dentist of their coverage under the HDS Plan. The failure of the member to notify the dentist of their coverage under the HDS Plan relieves HDS of its obligation to pay for the service and obligates the member to pay for the service.
- All claims for services must be submitted to HDS within 12 months of the service date in a format acceptable to HDS with all required documents. Claim forms are available on the HDS website. If a service is performed by an HDS participating dentist or Delta Dental participating dentist, then the failure of the dentist to submit the claim to HDS

in a format acceptable to HDS with all required documents within 12 months of the service date relieves both HDS and the member of their obligation to pay for the service. If a service is performed by a non-participating dentist, then the failure of the dentist or the member to submit the claim to HDS in a format acceptable to HDS with all required documents within 12 months of the date of service relieves HDS of its obligation to pay for the service.

- Coordination of Benefits
  - Members will inform their dentists of all dental plans in which they are enrolled at the time of service.
  - HDS applies the National Association of Insurance Commissioners rules, as amended from time to time, to determine the order in which each dental plan pays when a member is covered by more than one dental plan.
  - If a member is enrolled in multiple dental plans, the total of the HDS share and other dental plan payments will not exceed the allowed amount for a covered benefit under the HDS Plan.
  - When the HDS Plan is primary, the member's benefits under the HDS Plan are determined and payable before those of the other dental plans.
  - When the HDS Plan is secondary to other dental plans, then member's benefits under the HDS Plan are determined and payable after the other dental plans pay. The HDS share under the HDS Plan may be reduced or eliminated because of payment made by the primary dental plans.

CHAPTER 5:
Using plan coverage for Part D drugs

How can you get information about your drug costs?

Because you're eligible for Medicaid, you qualify for and are getting Extra Help from Medicare to pay for your prescription drug plan costs. Because you're in the Extra Help program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs does not apply to you**. We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug coverage. If you don't have this insert, call Member Services at 1-800-805-2739 (TTY users call 711) and ask for the LIS Rider. (Phone numbers for Member Services are printed on the back cover of this document.)

SECTION 1 Basic rules for our plan's Part D drug coverage

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

In addition to the drugs covered by Medicare, some prescription drugs are covered under your Medicaid benefits. Our Drug List tells you how to find out about your Medicaid drug coverage.

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

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

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

In most cases, your prescriptions are covered *only* if they're filled at our plan's network pharmacies. (Go to Section 2.4 for information about when we cover prescriptions filled at out-of-network pharmacies.)

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

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Provider and Pharmacy Directory*, visit our website (kp.org/directory), and/or call Member Services at 1-800-805-2739 (TTY users call 711).

You may go to any of our network pharmacies.

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. To find another pharmacy in your area, get help from Member Services at 1-800-805-2739 (TTY users call 711) or use the *Provider and Pharmacy Directory*. You can also find information on our website at kp.org/directory.

Specialized pharmacies

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting your Part D drugs in an LTC facility, call Member Services at 1-800-805-2739 (TTY users call 711).
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network. I/T/U pharmacies must be within our service area.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your *Provider and Pharmacy Directory* kp.org/directory or call Member Services at 1-800-805-2739 (TTY users call 711).

Section 2.2 Our plan's mail-order service

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

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

To get information about filling your prescriptions by mail, visit your local Kaiser Permanente pharmacy or call our mail-order pharmacy at 808-643-7979 (TTY 711), Monday through Friday, 8 a.m. to 5 p.m. You can conveniently order your prescription refills in the following ways:

- Register and order online securely at kp.org/refill.
- Call our Mail-order Pharmacy at 808-643-7979 (TTY 711).

When you order refills for home delivery online, by phone, or in writing, you must pay your cost-sharing when you place your order (there are no shipping charges for regular USPS mail delivery). If you prefer, you may designate a network pharmacy where you want to pick up and pay for your prescription. Please contact a network pharmacy if you have a question about whether your prescription can be mailed or see our Drug List for information about the drugs that can be mailed.

Usually, a mail-order pharmacy order will be delivered to you in no more than 5 days. If your mail-order prescription is delayed, please call the number listed above or on your prescription bottle's label for assistance. Also, if you cannot wait for your prescription to arrive from our mail-order pharmacy, you can get an urgent supply by calling your local network retail pharmacy listed in your *Provider and Pharmacy Directory* or at kp.org/directory. Please be aware that you may pay more if you get a 90-day supply from a network retail pharmacy instead of from our mail-order pharmacy.

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

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

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

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Provider and Pharmacy Directory* kp.org/directory tells you which pharmacies in our network can give you a long-term supply of maintenance

drugs. You can also call Member Services at 1-800-805-2739 (TTY users call 711) for more information.

2. You can also get maintenance drugs through our mail-order program. Go to Section 2.2 for more information.

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

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. **Check first with Member Services at 1-800-805-2739 (TTY users call 711)** to see if there's a network pharmacy nearby.

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

- If you are traveling within the United States and its territories but outside the service area and you become ill or run out of your covered Part D prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy in limited, nonroutine circumstances according to our Medicare Part D formulary guidelines.
- If you need a Medicare Part D prescription drug in conjunction with covered out-of-network emergency care or out-of-area urgent care, we will cover up to a 30-day supply from an out-of-network pharmacy. Note: Prescription drugs prescribed and provided outside of the United States and its territories as part of covered emergency or urgent care are covered up to a 30-day supply in a 30-day period. These drugs are not covered under Medicare Part D; therefore, payments for these drugs do not count toward reaching the catastrophic coverage stage.
- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24-hour service. We may not cover your prescription if a reasonable person could have purchased the drug at a network pharmacy during normal business hours.
- If you are trying to fill a prescription for a drug that is not regularly stocked at an accessible network pharmacy or available through our mail-order pharmacy (including high-cost drugs).
- If you are not able to get your prescriptions from a network pharmacy during a disaster.

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

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

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

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

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

The Drug List only shows drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered under your Medicaid benefits. The Drug List tells you how to find out about your Medicaid drug coverage.

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

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

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

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

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

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

Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7.)
- In other cases, we decided not to include a particular drug on the Drug List. In some cases, you may be able to get a drug that isn't on our Drug List. (For more information, go to Chapter 9.)

Please contact Medicaid to find out which drugs are covered under Medicaid (see Chapter 2 for contact information).

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

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

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

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

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

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

- Check the most recent Drug List we provided electronically.
- Visit our plan's website (kp.org/seniorrx). The Drug List on the website is always the most current.
- Call Member Services at 1-800-805-2739 (TTY users call 711) to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.
- Use our plan's "Real-Time Benefit Tool" (kp.org/seniorrx) to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on

the Drug List that could treat the same condition. You can also call Member Services at 1-800-805-2739 (TTY users call 711).

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

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

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

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

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Member Services at 1-800-805-2739 (TTY users call 711) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (Go to Chapter 9.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Member Services at 1-800-805-2739 (TTY users call 711) or on our website kp.org/seniorrx.

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

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

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.
- The drug is covered, but in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.
- **If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.**

If your drug isn't on the Drug List or is restricted, here are options for what you can do:

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

You may be able to get a temporary supply

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

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

- **If you're a new member,** we'll cover a temporary supply of your drug during the first **90 days** of your membership in our plan.
- **If you were in our plan last year,** we'll cover a temporary supply of your drug during the first **90 days** of the calendar year.
- This temporary supply will be for a maximum of 30 days. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:** We'll cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- **For current members with level of care changes:** If you enter into or are discharged from a hospital, skilled nursing facility, or long-term care facility to a different care setting or home, this is what is known as a level of care change. When your level of care changes, you may require an additional fill of your medication. We will generally cover up to a one-month supply of your Part D drugs during this level of care transition period even if the drug is not on our Drug List.

For questions about a temporary supply, call Member Services at 1-800-805-2739 (TTY users call 711).

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

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Member Services at 1-800-805-2739 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

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

If you and your provider want to ask for an exception, go to Chapter 9, Section 7.4 to learn what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

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

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Member Services at 1-800-805-2739 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

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

If you and your provider want to ask for an exception, go to Chapter 9, Section 7.4 for what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

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

SECTION 6 Our Drug List can change during the year

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

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

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

Information on changes to drug coverage

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

Changes to drug coverage that affect you during this plan year

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

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

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

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

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

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

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

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

SECTION 7 Types of drugs we don't cover

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

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

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

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.
- Our plan can't cover a drug purchased outside the United States or its territories.

- Our plan can't cover *off-label* use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs listed below aren't covered by Medicare. However, some of these drugs may be covered for you under your Medicaid drug coverage (please contact Medicaid for details):

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

If you get Extra Help to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 How to fill a prescription

To fill your prescription, provide our plan membership information (which can be found on your membership card) at the network pharmacy you choose. The network pharmacy will automatically bill our plan for our share of the costs of your drug. You'll need to pay the pharmacy *your* share of the cost when you pick up your prescription. Please be aware that you will need to show your Medicaid ID card when you get drugs covered by Medicaid that are excluded under Medicare Part D.

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

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

SECTION 9 Part D drug coverage in special situations

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

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

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

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

Check your *Provider and Pharmacy Directory* (kp.org/directory) to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Member Services at 1-800-805-2739 (TTY users call 711). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

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

Section 9.3 If you're in Medicare-certified hospice

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

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

SECTION 10 Programs on drug safety and managing medications

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

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

- Possible medication errors
- Drugs that may not be necessary because you take another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you take
- Unsafe amounts of opioid pain medications

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

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

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

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

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You'll have an opportunity to tell us which prescribers or pharmacies you prefer to

use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

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

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

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure our members get the most benefit from the drugs they take.

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

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

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Member Services at 1-800-805-2739 (TTY users call 711).

CHAPTER 6:
What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

We use “drug” in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are excluded from Part D coverage by law. Some of the drugs excluded from Part D coverage are covered under Medicare Part A or Part B or under Medicaid.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5 explains these rules. When you use our plan’s “Real-Time Benefit Tool” to look up drug coverage (kp.org/seniorrx), the cost you see shows an estimate of the out-of-pocket costs you’re expected to pay. You can also get information provided in the “Real-Time Benefit Tool” by calling Member Services at 1-800-805-2739 (TTY users call 711).

How can you get information about your drug costs?

Because you’re eligible for Medicaid, you qualify for and are getting Extra Help from Medicare to pay for your prescription drug plan costs. Because you have Extra Help, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs does not apply to you**. We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don’t have this insert, call Member Services at 1-800-805-2739 (TTY users call 711) and ask for the *LIS Rider*.

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

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

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

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

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

These payments <u>are included</u> in your out-of-pocket costs

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

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

Moving to the Catastrophic Coverage Stage:

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

These payments <u>aren't included</u> in your out-of-pocket costs

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

- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by our plan

- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling Member Services at 1-800-805-2739 (TTY users call 711).

Tracking your out-of-pocket total costs

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

SECTION 2 Drug payment stages for Kaiser Permanente Dual Complete members

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

- **Stage 1: Yearly Deductible Stage**
- **Stage 2: Initial Coverage Stage**
- **Stage 3: Catastrophic Coverage Stage**

SECTION 3 Your *Part D Explanation of Benefits* explains which payment stage you're in

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

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

- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

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

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

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

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

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track

of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**

- When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
- When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
- Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
- If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.

- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you get the *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or have questions, call Member Services at 1-800-805-2739 (TTY users call 711). You can also choose to view your *Part D EOB* online instead of by mail. Please visit kp.org/goinggreen and sign on to learn more about choosing to view your Part D EOB securely online. Be sure to keep these reports.

SECTION 4 The Deductible Stage

Because most of our members get Extra Help with their prescription drug costs, the Deductible Stage doesn't apply to most members. If you get Extra Help, this payment stage doesn't apply to you.

If you don't get Extra Help, the Deductible Stage is the first payment stage for your drug coverage. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.

For **Dual Complete Maui plan**, you'll pay a yearly deductible of **$615** on Tiers 4 and 5 drugs. **You must pay the full cost of your Tiers 4 and 5 drugs** until you reach our plan's deductible amount. For all other drugs, you won't have to pay any deductible.

For **Dual Complete Oahu plan**, you'll pay a yearly deductible of **$615** on Tiers 3, 4, and 5 drugs. **You must pay the full cost of your Tiers 3–5 drugs** until you reach our plan's deductible amount. For all other drugs, you won't have to pay any deductible.

The **full cost** is usually lower than the normal full price of the drug since our plan negotiated lower costs for most drugs at network pharmacies. The full cost cannot exceed the maximum fair price plus dispensing fees for drugs with negotiated prices under the Medicare Drug Price Negotiation Program.

Once you pay $615 for your Tiers 4-5 drugs for **Dual Complete Maui plan**, or $615 for your Tiers 3–5 drugs for **Dual Complete Oahu plan**, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

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

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

Our plan has 6 cost-sharing tiers

Every drug on our plan's Drug List is in one of 6 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Cost-sharing **Tier 1** for preferred generic drugs (this tier includes some brand-name drugs). You pay **$0** per month supply of each covered insulin product on this tier.
- Cost-sharing **Tier 2** for generic drugs (this tier includes some brand-name drugs). You pay **$0** per month supply of each covered insulin product on this tier.
- Cost-sharing **Tier 3** for preferred brand-name drugs (this tier includes both generic and brand-name drugs). You pay **$0** per month supply of each covered insulin product on this tier.
- Cost-sharing **Tier 4** for nonpreferred drugs (this tier includes both generic and brand-name drugs). You pay **$0** per month supply of each covered insulin product on this tier.
- Cost-sharing **Tier 5** for specialty-tier drugs (this tier includes both generic and brand-name drugs). You pay **$0** per month supply of each covered insulin product on this tier.
- Cost-sharing **Tier 6** for injectable Part D vaccines (this tier includes only brand-name drugs).

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

Your pharmacy choices

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

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

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

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

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

The amount of the copayment or coinsurance depends on the cost-sharing tier.

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

Your costs for a *one-month* supply of a covered Part D drug

Tier	Retail cost sharing (in-network)	Mail-order cost sharing	Long-term care (LTC) cost sharing	Out-of-network cost sharing (Coverage is limited to certain situations; go to Chapter 5 for details.)
	(up to a 30-day supply)		(up to a 31-day supply)	(up to a 30-day supply)
Tier 1 – Preferred generic drugs (All Plans)	**$0**			

Tier	Retail cost sharing (in-network) (up to a 30-day supply)	Mail-order cost sharing	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; go to Chapter 5 for details.) (up to a 30-day supply)
Tier 2 – Generic drugs (All Plans)	**$0**			
Tier 3 – Preferred brand-name drugs				
• Maui plan	**17% coinsurance**			
• Oahu plan	**25% coinsurance**			
Tier 4 – Nonpreferred drugs (All Plans)	**25% coinsurance**			
Tier 5 – Specialty-tier drugs (All Plans)	**25% coinsurance**			
Tier 6 – Injectable Part D vaccines (All Plans)	**$0**	**Mail-order isn't available for drugs in Tier 6.**	**$0**	

You won't pay more than **$0** for up to a one-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.

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

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

Typically, the amount you pay for a drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for

example, when you're trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply if this will help you better plan refill dates.

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

- If you're responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you're responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We calculate the amount you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you get.

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

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

Your costs for a *long-term* (up to a 90-day) supply of a covered Part D drug

Tier	Retail cost sharing (in-network)		Mail-order cost sharing	
	31- to 60-day supply	61- to 90-day supply	31- to 60-day supply	61- to 90-day supply
Tier 1 – Preferred generic drugs (All Plans)	**$0**			
Tier 2 – Generic drugs (All Plans)	**$0**			
Tier 3 – Preferred brand-name drugs				
• Maui plan	**17% coinsurance**			
• Oahu plan	**25% coinsurance**			

Tier	Retail cost sharing (in-network)		Mail-order cost sharing	
	31- to 60-day supply	61- to 90-day supply	31- to 60-day supply	61- to 90-day supply
Tier 4 – Nonpreferred drugs (All Plans)	**25% coinsurance**			
Tier 5 – Specialty-tier drugs (All Plans)	**25% coinsurance**			
Tier 6 – Injectable Part D vaccines (All Plans)	**A long-term supply isn't available for drugs in Tier 6.**			

You won't pay more than **$0** for up to a 2-month supply and **$0** for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier, even if you haven't paid your deductible.

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

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

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

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

SECTION 6 The Catastrophic Coverage Stage

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

SECTION 7 What you pay for Part D vaccines

Important message about what you pay for vaccines – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D

vaccines at no cost to you even if you haven't paid your deductible. Go to our plan's Drug List or call Member Services at 1-800-805-2739 (TTY users call 711) for coverage and cost-sharing details about specific vaccines.

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

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

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

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

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

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

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

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

- For most adult Part D vaccines, you pay nothing.

- For other Part D vaccines, you pay the pharmacy your copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

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

- When you get the vaccine, you may have to pay the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any copayment for the vaccine (including administration).

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

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

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

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

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

Our network providers bill our plan directly for your covered services and drugs. If you get a bill for the full cost of medical care or drugs you got, send this bill to us so that we can pay it. When you send us the bill, we'll look at the bill and decide whether the services and drugs should be covered. If we decide they should be covered, we'll pay the provider directly.

If you already paid for a Medicare service or item covered by our plan, you can ask our plan to pay you back (paying you back is often called **reimburse** you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter. When you send us a bill you've already paid, we'll look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we'll pay you back for the services or drugs.

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

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

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

   - 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, ask the provider to bill our plan.
   - 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 that you think you don't owe. Send us this bill, along with documentation of any payments you made.
  - If the provider is owed anything, we'll pay the provider directly.
  - If you already paid more than your share of the cost for 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. But sometimes they make mistakes and ask you to pay more than your share of the cost.

- 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. Ask us to pay you back for the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

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

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

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

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

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

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

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

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

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

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

- For example, the drug may not be on our plan's Drug List or it could have a requirement or restriction you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor to pay you back for our share of the cost of the drug. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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

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

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you'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 (for Part C medical claims) and within 36 months (for Part D drug claims) of the date you got the service, item, or drug.

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

- You don't have to use the form, but it will help us process the information faster. You can file a claim to request payment by:

- Completing and submitting our electronic form at kp.org and upload supporting documentation.
- Download a copy of the form from our website (kp.org) or call Member Services at 1-800-805-2739 (TTY users call 711) and ask for the form.
- 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
Hawaii Region
P.O. Box 378021
Denver, CO 80237

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

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

- If we decide the medical care or drug is covered and you followed all the rules, we'll pay for our share of the cost for the service or drug. If you already paid for the service or drug, we'll mail your reimbursement of our share of the cost to you. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.

- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost of the care or drug. 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 we won't pay for all or part of the medical care or drug, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9.

CHAPTER 8:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan 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. We can also give you materials in languages other than English and large font, braille, audio file, or data CD at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at 1-800-805-2739 (TTY users call 711).

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

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Member Services at 1-800-805-2739 (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.

Seksion 1.1 Kasapulan nga maipa-aymi ti impormasion iti wagas nga mayat para kenka ken nga makatunos kadagiti kultural a sensibilidadmo (kadagiti pagsasao malaksid iti Ingles, large font, braille, audio file, wenno data CD)

Kasapulan ti planomi tapno maisigurado nga amin a serbisio, ti klinikal ken saan a klinikal, ket maipaay iti wagas a maiyannatup ti kultura ken magun-od dagiti amin a nagpalista, agraman dagiti nabeddengan ti panagsao da iti Ingles, nabeddengan ti kabaelan da iti panagbasa, disabilidad ti panagdengngeg, wenno dagitay addaan kadagiti agduduma a nagappuan a kultura ken etnisidad. Dagiti ehemplo nu kasatno nga mapnekan daytoy plano mi dagiti accessibility requirements ket agraman ngem haan nga limitado iti panangited iti serbisyo nga panagtranslate, panaginterpret, teletypewriters wenno koneksyon iti TTY (text telephone or teletypewriter phone).

Daytoy plano mi ket ada iti libre nga serbisyo nga panaginterpret nga mangsumbat kadagiti damag yu magapo iti miyembro nga haan nga makabalikas iti Ingles. Mabalin mi met laeng nga agited impormasyon iti dadduma nga lenggwahe haan laeng nga iti Ingles nu di pay pati iti Espanyol ken dadakel nga surat, braille, audio file, wenno data CD iti awan bayad na nu kasapulan yu. Dakami ket namandoan nga agited kanyayo iti impormasyon gapo dagiti benepisyo iti plano mi iti porma nga nalaka yo nga magun-od ken maiyannatop kanyayo. Tapno makagun-od iti impormasion manipud kadakami iti wagas nga agtrabaho para kenka, tawagan dagiti serbisio ti miembro iti 1-800-805-2739 (TTY users call 711).

Maikasapulan iti planomi a mangiyawat kadagiti babbai a nagpalista ti pagpilian iti tarus nga access ti espesialista iti salun-at dagiti babbai iti uneg ti network para kadagiti serbisio ti rutina ken manglapped a panangtaripato ti salun-at kadagiti babbai.

Tapno maala yo iti impormasyon magapo kanya mi iti dalan nga umannatop para kanyayo, tawagan yo ti Member Services iti daytoy nga numero, 1-800-805-2739 (TTY users call 711). Iti daytoy nga sitwasyon, iti bayadam laeng ket diyay in-network cost sharing. Nu mabirukan yo iti bagi yo iti sitwasyon nga awan iti espesyalista iti network ti plano nga mangited iti serbisyo nga kasapulan yo, tawagan yo iti plano para iti impormasyon nu sadino ti pangsapulan yo iti dayta nga serbisyo babaen iti in-network cost sharing.

Nu adda iti parikut yo iti panangala yo iti impormasyon magapo ti plano mi iti porma nga nalaka nga magun-od ken maiyanatop kanyayo, akas iti panangsapol iti espesyalista ti salun-at ti babbai wenno iti panangsapol ti network nga espesyalista, tawagan yo iti daytoy nga numero tapno mangifile kayo iti maysa a grievance idjay Member Services at 1-800-805-2739 (TTY users call 711) Mabalin yo met laeng nga mangisubmitar iti maysa a reklamo idjay Medicare babaen iti panagtawag yo ti 1-800-MEDICARE (1-800-633-4227) wenno direkta yo nga tawagan ti Office for Civil Rights iti daytoy nga numero 1-800-368-1019 wenno TTY 1-800-537-7697.

Mục 1.1 Chúng tôi phải cung cấp thông tin theo cách phù hợp với quý vị và phù hợp với các yếu tố nhạy cảm về văn hóa của quý vị (bằng các ngôn ngữ khác ngoài tiếng Anh, phông chữ lớn, chữ nổi Braille, tệp âm thanh hoặc CD dữ liệu)

Chương trình của chúng tôi phải đảm bảo rằng tất cả các dịch vụ, cả lâm sàng và phi lâm sàng, được cung cấp theo cách phù hợp với văn hóa và dễ tiếp cận với tất cả những người ghi danh tham gia, bao gồm cả những người có trình độ tiếng Anh hạn chế, kỹ năng đọc hạn chế, khiếm thính hoặc những người có nền tảng văn hóa và nguồn gốc dân tộc đa dạng. Ví dụ về cách chương trình của chúng tôi có thể đáp ứng các yêu cầu về khả năng tiếp cận này bao gồm nhưng không giới hạn ở việc cung cấp dịch vụ dịch thuật, dịch vụ thông dịch, máy chữ điện báo hoặc kết nối TTY (điện thoại tin nhắn hoặc điện thoại máy đánh chữ).

Chương trình chúng tôi có dịch vụ thông dịch miễn phí để giải đáp những thắc mắc từ hội viên không nói tiếng Anh. Chúng tôi cũng có thể cung cấp cho quý vị thông tin bằng các ngôn ngữ khác ngoài Tiếng Anh bao gồm Tiếng Tây Ban Nha và phông chữ lớn, chữ nổi Braille, tệp âm thanh hoặc đĩa CD dữ liệu miễn phí nếu quý vị cần. Chúng tôi được yêu cầu cung cấp cho quý vị thông tin về các quyền lợi từ chương trình của chúng tôi ở định dạng dễ tiếp cận và phù hợp với quý vị. Để nhận thông tin từ chúng tôi theo cách phù hợp với quý vị, hãy gọi đến Dịch Vụ Hội Viên theo số 1-800-805-2739 (người dùng TTY hãy gọi số 711).

Chương trình của chúng tôi phải cung cấp cho những người ghi danh tham gia là nữ tùy chọn tiếp cận trực tiếp với một bác sĩ chuyên khoa sức khỏe phụ nữ trong mạng lưới đối với các dịch vụ chăm sóc sức khỏe định kỳ và phòng ngừa cho phụ nữ.

Nếu các nhà cung cấp trong mạng lưới của chúng tôi về một chuyên khoa không có sẵn, chúng tôi có trách nhiệm tìm các nhà cung cấp chuyên khoa bên ngoài mạng lưới có thể cung cấp cho quý vị dịch vụ chăm sóc cần thiết. Trong trường hợp này, quý vị sẽ chỉ phải trả phần chia sẻ chi phí trong mạng lưới. Nếu quý vị gặp phải tình huống không có bác sĩ chuyên khoa nào trong mạng lưới của chúng tôi cung cấp dịch vụ quý vị cần, hãy gọi cho chúng tôi để biết thông tin về nơi cần đến để có được dịch vụ này với phần chia sẻ chi phí trong mạng lưới.

Nếu quý vị gặp bất kỳ khó khăn nào trong việc nhận thông tin từ chương trình của chúng tôi theo định dạng dễ tiếp cận và phù hợp với quý vị, khám bác sĩ chuyên khoa sức khỏe phụ nữ hoặc tìm một bác sĩ chuyên khoa trong mạng lưới, hãy gọi để nộp đơn phàn nàn tới Dịch Vụ Hội Viên theo số 1-800-805-2739 (người dùng TTY hãy gọi số 711). Quý vị có thể nộp đơn than phiền với Medicare bằng cách gọi 1-800-MEDICARE (1-800-633-4227) hoặc gọi trực tiếp tới Văn Phòng Dân Quyền 1-800-368-1019 hoặc TTY 1-800-537-7697.

第1.1節 我們必須以便於您使用的方式提供資訊，同時符合您的文化敏感度（以英文以外的其他語言、大字版、點字版、音訊檔案或資料光碟 [Compact Disc, CD] ）

我們的計劃需要確保所有服務，都能在文化能力上為所有參保人提供包括臨床和非臨床服務，包括英語水準或閱讀能力有限、聽力喪失，或具有不同文化和族裔背景的人。我們的

計劃能如何滿足這些便利設施要求的範例包括但不限於：提供筆譯服務、口譯服務、電傳打字機或聽障及語障電話專線 (Teletypewriter, TTY)（文字電話或電傳打字機電話）的聯繫。

本計劃提供免費口譯服務，為非英語的會員解答疑問。如有需要，我們也可免費為您提供英文以外的語言（包括西班牙文）、大字版、點字版、音訊檔案或資料光碟 (CD) 的資訊。我們必須以您能夠使用且適用於您的格式為您提供計劃福利相關資訊。若要經由我們取得您能夠使用的資訊，請致電會員服務部，電話為1-800-805-2739（聽障及語障電話專線 [TTY] 使用者請撥打711）。

本計劃需要在婦女常規及預防保健服務方面，向女性入保人提供直接於網絡內婦女健康專科醫生處就診的選項。

如果本計劃網絡中的專科醫護人員無法提供服務，本計劃有責任在網絡外找到專科醫護人員，並為您提供所需的醫護服務。在此情況下，您僅需支付網絡內成本分擔費用。如果您發現自己處於在我們的計劃網絡內，但沒有包含您所需要的服務專科醫生的情況下，請致電我們，瞭解何處能以網絡內成本分擔的方式獲取此服務的相關資訊。

如果您在透過該計劃獲取您能夠使用且適用於您之格式的資訊、於婦女健康專科醫生處就診，或在尋找網絡內專科醫生時遭遇任何困難， 請致電會員服務部提交投訴，電話為1-800-805-2739（聽障及語障電話專線 [TTY] 使用者請撥打711）。您也可致電1-800-MEDICARE (1-800-633-4227) 向聯邦醫療保險計劃 (Medicare) 提出投訴，或者致電1-800-368-1019或聽障及語障電話專線 (TTY) 1-800-537-7697，向民權辦公室直接投訴。

섹션 1.1 가입자의 문화적 민감성에 부합하는 방식으로 정보를 제공합니다(영어가 아닌 언어, 큰 활자, 점자, 음성 파일 또는 데이터 CD)

저희 플랜은 영어 유창성, 읽기 능력, 듣기 능력이 부족한 사람들이나 문화적, 인종적 배경이 다른 사람들을 포함하여 가입자 모두가 문화적으로 적합하고 이용하기 쉬운 임상 및 비임상 서비스를 제공해야 합니다. 저희 플랜이 이 같은 접근성 요건을 충족하는 방법으로는 번역 서비스, 통역 서비스, 텔레타이프라이터, TTY(문자 전화 또는 텔레타이프라이터 전화) 연결 등이 포함되지만 이에 국한되지 않습니다.

저희 플랜은 영어를 사용하지 않는 가입자 여러분의 문의에 답변을 드리기 위해 무료 통역 서비스가 있습니다. 스페인어를 포함한 영어 이외의 언어로 된 자료, 큰 글씨체 자료, 점자 자료, 오디오 파일, 데이터 CD 등이 필요하신 경우 무료로 제공해 드립니다. 저희는 이용 가능하고 적절한 형식으로 준비된 저희 플랜의 보험 혜택에 관한 정보를 가입께 제공해드릴 의무가 있습니다. 귀하에게 맞는 방식으로 정보를 얻으려면 1-800-805-2739(TTY 사용자는 711로 전화)로 가입자 서비스에 전화하십시오.

저희 플랜은 여성 가입자에게 네트워크 내에서 여성 건강 전문의에게 여성의 일상적 및 예방적 건강 관리 서비스를 받을 수 있는 옵션을 제공해야 합니다.

저희 네트워크 내에 의료 서비스 제공자가 없을 경우 네트워크 밖에서 필요한 진료를 제공할 수 있는 전문 의료 서비스 제공자를 찾아 드립니다. 이 경우 가입자께서는 네트워크 분담 비용만 부담하시면 됩니다. 저희 네트워크에 필요한 서비스를 담당하는 전문가가 없는 상황이라면 네트워크 분담 비용으로 해당 서비스를 받을 수 있는 곳을 안내해드립니다.

귀하에게 접근 가능하고 적합한 형식으로 당사 플랜에 대한 정보를 얻는 데 어려움이 있거나, 여성 건강 전문의를 만나거나, 네트워크 전문가를 찾는 데 어려움이 있는 경우, 1-800-805-2739(TTY 사용자는 711로 전화)로 전화하여 가입자 서비스에 불만을 제기하십시오. 또한 Medicare 전화번호 1-800-MEDICARE(1-800-633-4227)로 전화하여 불만을 제기하시거나 민권 사무소(1-800-368-1019 또는 TTY 1-800-537-7697)로 직접 연락하실 수 있습니다.

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

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

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

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

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

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.

- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you'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 are 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 are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; 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 at our plan, and to get a copy of your records. We're allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we'll work with your health care provider to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, call Member Services at 1-800-805-2739 (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 1-800-805-2739 (TTY users call 711):

- **Information about our plan**. This includes, for example, information about our plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.

- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D drug coverage.
- **Information about why something isn't covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug isn't covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

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

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

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

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

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

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

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.

- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

Legal documents you can use to give directions in advance 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 1-800-805-2739 (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 did not follow the instructions in it, you can file a complaint with the Office of Health Care Assurance, Hawaii State Department of Health, by calling (808) 692-7420 or write to Department of Health, Medicare Section, 601 Kamokila Boulevard, Room 395, Kapolei, HI 96707.

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 9 of this document tells what you can do. Whatever you do—ask for a

coverage decision, make an appeal, or make a complaint—**we're required to treat you fairly**.

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

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

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

- **Call our plan's Member Services at 1-800-805-2739 (TTY users call 711)**
- **Call your local SHIP** at 1-888-875-9229 (TTY 1-866-810-4379)
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)
- You can call Department of Human Services Med-QUEST Division. For details, go to Chapter 2, Section 6.
- Or, you can call Hawaii Department of Health Care Services Office of the Ombudsman For details, go to Chapter 2, Section 6.

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services at 1-800-805-2739 (TTY users call 711)**
- **Call your local SHIP** at 1-888-875-9229 (TTY 1-866-810-4379)
- **Contact Medicare**
  - Visit www.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 1-800-805-2739 (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 1-800-805-2739 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
  - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care or Part D drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
  - Make sure you understand your health problems and participate in developing mutually agreed upon treatment goals with your providers whenever possible.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - You must continue to pay your Medicare premiums to stay a member of our plan.

  - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.

- **If you 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 9:
If you have a problem or complaint (coverage decisions, appeals, complaints)

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

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on the type of problem you're having:

- 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).

Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Section 3 will help you identify the right process to use and what you should 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 1-800-805-2739 (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 are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program isn't 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. Contact Hawaii SHIP at 1-888-875-9229 (TTY 1-866-810-4379).

Medicare

You can also contact Medicare for help:

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

You can get help and information from Medicaid

For more information and help in handling a problem, you can also contact the Department of Human Services Med-QUEST Division (Hawaii's Medicaid program).

Here are two ways to get information directly from Medicaid:

- You can call 808-524-3370 or 1-800-316-8005. TTY users should call 711.
- You can visit the Department of Human Services Med-QUEST Division website (www.medquest.hawaii.gov).

SECTION 3 Understanding Medicare and Medicaid complaints and appeals

You have Medicare and get help from Medicaid. Information in this chapter applies to **all** your Medicare and Medicaid benefits. This is called an integrated process because it combines, or integrates, Medicare and Medicaid processes.

Sometimes the Medicare and Medicaid processes aren't combined. In those situations, use a Medicare process for a benefit covered by Medicare and a Medicaid process for a benefit covered by Medicaid. These situations are explained in **Section 6.4**.

SECTION 4 Which process to use for your problem

If you have a problem or concern, read the parts of this chapter that apply to your situation. The information below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare or Medicaid**.

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're covered, and problems related to payment for medical care.

Yes.

Go to **Section 5, A guide to coverage decisions and appeals.**

No.

Go to **Section 11**, **How to make a complaint about quality of care, waiting times, customer service, or other concerns.**

Coverage decisions and appeals

SECTION 5 A guide to coverage decisions and appeals

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

Asking for coverage decisions before you get services

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

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

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

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

Making an appeal

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

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

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

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go 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 6.4** of this chapter for more information about Level 2 appeals for medical care.
- Part D appeals are discussed in Section 7 of this chapter.

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 5.1 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** 1-800-805-2739 (TTY users call 711)
- **Get free help** from your State Health Insurance Assistance Program
- **Your doctor or other health care provider 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 1-800-805-2739 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at kp.org.)
    - For medical care, your doctor or other health care provider can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it'll be automatically forwarded to Level 2.
    - If your doctor or other health provider asks that a service or item that you're already getting be continued during your appeal, you **may** need to name your doctor or other prescriber as your representative to act on your behalf.
    - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.

If you want a friend, relative, or other person to be your representative, call Member Services at 1-800-805-2739 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at kp.org.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.

We can accept an appeal request from a representative without the form, but we can't begin or 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 also 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 5.2 Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines, we give the details for each of these situations:

- **Section 6:** "Medical care: How to ask for a coverage decision or make an appeal"
- **Section 7:** "Part D drugs: How to ask for a coverage decision or make an appeal"
- **Section 8:** "How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon"
- **Section 9:** "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies only to these services:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Member Services at 1-800-805-2739 (TTY users call 711). You can also get help or information from your SHIP.

SECTION 6 Medical care: How to ask for a coverage decision or make an appeal

Section 6.1 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 our plan covers this care. **Ask for a coverage decision. Section 6.2.**
2. Our plan won't approve the medical care your doctor or other health care provider wants to give you, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**
3. You got medical care that you believe our plan should cover, but we said we won't pay for this care. **Make an appeal. Section 6.3.**
4. You got and paid for medical care that you believe our plan should cover, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**

5. You're told that coverage for certain medical care you've been getting (that we previously approved) will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

   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 8 and 9. Special rules apply to these types of care.

Section 6.2 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, 24 hours for Part B drugs.

- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a fast coverage decision, we'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 11 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 should *not* take extra days, you can file a fast complaint. (Go to Section 11 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 6.3 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 6.2.

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

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

If we told you we were going to stop or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.

- If we decided to change or stop coverage for a service or item that you currently get, we'll send you a notice before taking the proposed action.
- If you disagree with the action, you can file a Level 1 appeal. We'll continue covering the service or item if you ask for a Level 1 appeal within 10 calendar days of the

postmark date on our letter or by the intended effective date of the action, whichever is later.

- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 appeal is pending. You'll also keep getting all other services or items (that aren't the subject of your appeal) with no changes.

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

- When we are 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. Section 6.4 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. (For more information about the process for making complaints, including fast complaints, go to **Section 11**.)
- If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal where an independent review organization will review the appeal. Section 6.4 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**, 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, you have additional appeal rights.
- If we say no to part or all of what you asked for, we'll send you a letter.
  - If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the independent review organization for a Level 2 appeal.
  - If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file a Level 2 appeal yourself.

Section 6.4 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.

- If your problem is about a service or item that's usually **covered by Medicare**, we'll automatically send your case to Level 2 of the appeals process as soon as the Level 1 appeal is complete.
- If your problem is about a service or item that's usually **covered by Medicaid**, you can file a Level 2 appeal yourself. The letter will tell you how to do this. Information is also below.

- If your problem is about a service or item that could be **covered by both Medicare and Medicaid**, you'll automatically get a Level 2 appeal with the independent review organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Go to page 135-137 for information about continuing your benefits during Level 1 appeals.

- If your problem is about a service that's usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the independent review organization.
- If your problem is about a service that's usually covered by Medicaid, your benefits for that service will continue if you submit a Level 2 appeal within 10 calendar days after getting our plan's decision letter.

If your problem is about a service or item Medicare usually covers:

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 free copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information about your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

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

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.

- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

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

The independent review organization will tell you it's 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 the independent review organization says no to part or all of your appeal**, it means they agree with our plan 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 you're requesting 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.
- If your Level 2 appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go to Level 3 and make a third 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 10** in this chapter explains the process for Level 3, 4, and 5 appeals.

If your problem is about a service or item Medicaid usually covers:

Step 1: Ask for a Fair Hearing with the state.

- Level 2 of the appeals process for services usually covered by Medicaid is a Fair Hearing with the state. You must ask for a Fair Hearing in writing or over the phone **within 120 calendar days** of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request.

Step 2: The Fair Hearing office gives you its answer.

The Fair Hearing office will tell you its decision in writing and explain the reasons.

- **If the Fair Hearing office says yes to part or all of a request for a medical item or service,** we must authorize or provide the service or item within 72 hours after we get the decision from the Fair Hearing office.
- **If the Fair Hearing office says no to part or all of your appeal**, they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision** or **turning down your appeal.**)

If the decision is no for all or part of what you asked for, you can make another appeal.

If the independent review organization or Fair Hearing office decision is no for all or part of what you asked for, you have **additional appeal rights**.

The letter you get from the Fair Hearing office will describe this next appeal option.

Go to **Section 10** for more information on your appeal rights after Level 2.

Section 6.5 If you're asking us to pay you back for our share of a bill you got for medical care

If you have already paid for a Medicaid service or item covered by our plan, ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid for medical services or drugs that are covered by our plan. When you send us a bill you already paid, we'll look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we'll pay you back for the services or drugs.

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 you want us to reimburse you for a **Medicare** service or item or you're asking us to pay a health care provider for a Medicaid service or item you paid for, ask us to make this coverage

decision. We'll check to see if the medical care you paid for is a covered service. We'll also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment for the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request.

If the Medicaid care that you paid a health care provider for is covered and you think we should pay the health care provider instead, we'll send your health care provider the payment for the cost within 60 calendar days after we get your request.

Then you'll need to contact your health care provider to get them to pay you back. If you haven't paid for the medical care, we'll send the payment directly to the health care provider.

- **If we say no to your request:** If the medical care isn't 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 6.3. For appeals concerning reimbursement, note:

- We must give you our answer within 30 calendar days after we get your 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 health care provider within 60 calendar days.

SECTION 7 Part D drugs: How to ask for a coverage decision or make an appeal

Section 7.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D* drug every time. We also use the term Drug List instead *of List of Covered Drugs* or formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term:

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that's not on our plan's Drug List. **Ask for an exception. Section 7.2.**
- Asking to waive a restriction on our plan's coverage for a drug (such as prior authorization criteria). **Ask for an exception. Section 7.2.**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 7.2.**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4.**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4.**

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

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 7.2 Asking for an exception

Legal Terms:

Asking for coverage of a drug that's not on the Drug List is a **formulary exception**.

Asking for removal of a restriction on coverage for a drug is a **formulary exception**.

Asking to pay a lower price for a covered non-preferred drug is a **tiering exception**.

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to drugs in Tier 5 (specialty tier) for brand name drugs or Tier 2 for generic drugs. You can't ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you pay as your share of the cost of the drug.
    - If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
    - If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing. This would be the lowest tier that contains biological product alternatives for treating your condition.
    - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
    - If the drug you're taking is a generic drug, you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
    - You can't ask us to change the cost-sharing tier for any drug in Tier 5 (specialty-tier drugs).
    - If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List typically includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you're requesting and wouldn't cause more side effects or other health problems, we generally won't approve your request for an exception. If you ask us for a tiering exception, we generally won't approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of our plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 7.4 How to ask for a coverage decision, including an exception

Legal term:

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

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

Standard coverage decisions are made within **72 hours** after we get your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet 2 requirements:**

- You must be asking for a *drug you didn't get yet*. (You can't ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request* form, which is available on our website kp.org/directory. Chapter 2 has contact information. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you're asking for an exception, provide the supporting statement,** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

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

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we get your request.
  - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.

- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must give you our answer **within 72 hours** after we get your request.
    - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
    - If we don't meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for,** we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

- We must give you our answer **within 14 calendar days** after we get your request.

If we don't meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

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

Section 7.5 How to make a Level 1 appeal

Legal Terms:

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

A fast appeal is called an **expedited redetermination**.

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

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you're appealing a decision we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 7.4.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request.** Chapter 2 has contact information.
- **For fast appeals, either submit your appeal in writing or call us at 1-800-805-2739 (TTY users call 711)**. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website (kp.org). Include your name, contact information, and information about your claim to help us process your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
    - If we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request.

- If we don't meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within 30 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

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

Legal Term

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

The **independent review organization is an independent organization hired by Medicare**. It 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: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you'll include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.
- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE.
- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all the information about your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the independent review organization agrees to give you a fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** after it gets your appeal request.

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it gets your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you have already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

Step 3: The independent review organization gives you its answer.

For fast appeals:

- **If the independent review organization says yes to part or all of what you asked for,** we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we get the decision from the independent review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

What if the independent review organization says no to your appeal?

If the independent organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision** 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 drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go 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 10** talks more about the process for Level 3, 4, and 5 appeals.

SECTION 8 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 8.1 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 1-800-805-2739 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
    - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
    - Your right to be involved in any decisions about your hospital stay.
    - Where to report any concerns you have about the quality of your hospital care.
    - Your right to **ask for an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we'll cover your hospital care for a longer time.
2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**
    - You or someone who is acting on your behalf will be asked to sign the notice.
    - Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice ***doesn't*** **mean** you're agreeing on a discharge date.
3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.
    - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
    - To look at a copy of this notice in advance, call Member Services at 1-800-805-2739 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at www.CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 8.2 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 1-800-805-2739 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP), for personalized help. Contact Hawaii SHIP at 1-888-875-9229 (TTY 1-866-810-4379). SHIP contact information is available in Chapter 2, Section 3.

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

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
    - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
    - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay 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 are contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at 1-800-805-2739 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). (TTY users call

1-877-486-2048.) Or you can get a sample notice online at www.CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

Section 8.3 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 it's decision.

If the independent review organization says yes:

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

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- 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 10** talks more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 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 is time to stop covering any of the 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 9.1 We'll tell you in advance when your coverage will be ending

Legal Term:

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

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
    - The date when we'll stop covering the care for you.
    - How to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got 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 9.2 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 1-800-805-2739 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. Contact Hawaii SHIP at 1-888-875-9229 (TTY 1-866-810-4379). SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

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

How can you contact this organization?

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

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization.

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 to.
- 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 it's decision.

What happens if the reviewers say yes?

- If the reviewers say yes to your appeal, then **we must keep providing your covered service 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 9.3 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 could 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 it's decision.

What happens if the independent review organization says yes?

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

What happens if the independent review organization says no?

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

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

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go 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 10 of this chapter tells more about the process for Level 3, 4, and 5 appeals.

SECTION 10 Taking your appeal to Levels 3, 4 and 5

Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

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

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at 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's favorable to you. We'll decide whether to appeal this decision to Level 5.
- If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
- If we decide to appeal the decision, we'll let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
- If you decide to accept this decision that turns down your appeal, the appeals process is over.
- If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

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

Section 10.2 Additional Medicaid appeals

You also have other appeal rights if your appeal is about services or items that Medicaid usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

DHS administrative hearing:

If you have gone through Kaiser Permanente's appeal process and are not happy with the decision, we made about your appeal you can ask Department of Human Services (DHS) for an administrative hearing. Write to the Administrative Appeals Office (AAO) of DHS. The AAO must receive your letter within 120 calendar days from when you got Kaiser Permanente's notice of denial disposition about your appeal. Include information: any statements of fact or laws to support your request. Send your appeal to:

State of Hawaii Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809-0339

There is no cost to receive copies of the appeal file. You have the right to name someone to file the appeal for you. You must name that person in writing when you send your appeal. You may represent yourself at the hearing or you may have a lawyer, a relative, a friend, or someone else there to speak for you. You will receive a decision within 90 calendar days from the date they received your request. We must follow the decision of the DHS administrative hearing. You must go through Kaiser Permanente's appeal process first before asking for a DHS administrative hearing.

You or your approved representative, is considered to have used up Kaiser Permanente's grievance and appeal process if Kaiser Permanente does not follow the notice and timing requirements set by Med-QUEST Division of DHS. When this happens, you have the right to file for a state administrative hearing. Members must exhaust Kaiser Permanente's internal grievance and appeals system before accessing the state's administrative hearing system.

Expedited DHS administrative hearing

If you had an expedited review of your appeal with us, and it didn't go the way you wanted it to, then you may ask DHS for an expedited administrative hearing. You must submit your letter to the AAO within 120 calendar days of getting your answer from Kaiser Permanente about your appeal. An expedited administrative hearing needs to be reviewed and decided upon within three business days from when your request was filed. We will work with the state to ensure that the best results are provided for you and to ensure that the procedures comply with state and federal regulations. When an expedited state administrative hearing is requested, we will submit information that was used to make the determination, for example, medical records, written documents to and from you, provider notes, etc. to DHS within 24 hours of the decision denying the expedited appeal.

Please send your request for an expedited state administrative hearing process to:

State of Hawaii Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809-0339

Section 10.3 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over.**
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

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

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for**

expedited appeals) or make payment no later than 30 calendar days after we get the decision.

- **If the answer is no 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 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 11.1 What kinds of problems are handled by the complaint process

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?

Complaint	Example
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan? ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are about the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 11.2 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 1-800-805-2739 (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.
- **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. 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.
- Whether you call or write, you should call Member Services at 1-800-805-2739 (TTY users call 711) right away. You can make the complaint at any time after 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 11.3 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 11.4 You can also tell Medicare and Medicaid about your complaint

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

Also, you may ask for a state grievance review from the State of Hawaii's Department of Human Services Med-QUEST Division. You must call or write to Med-QUEST within 30 days of receipt of grievance disposition from the health plan. If you do not do this, your complaint will be considered resolved.

To ask for a state grievance review, call DHS at 808-692-8094. Or mail request to:

Med-QUEST Division
Health Care Services Branch
PO Box 700190
Kapolei, HI 96709-0190

DHS will review your complaint. They will decide on it within 90 calendar days from the day the request for a grievance review is received. DHS's decision will be final.

CHAPTER 10:
Ending membership in our plan

SECTION 1 Ending your membership in our plan

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

- You might leave our plan because you decide you *want* to leave. 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 prescription drugs, and you'll continue to pay your cost share until your membership ends.

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

Section 2.1 You may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare *without* a separate Medicare prescription drug plan (If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- Call your State Medicaid Office at 808-524-3370 or 1-800-316-8005 (TTY 711) to learn about your Medicaid plan options.
- Other Medicare health plan options are available during the **Open Enrollment Period**. Section 2.2 tells you more about the Open Enrollment Period.

- **Your membership will usually end on the first day of the month after we get your request to change your plans.** Your enrollment in your new plan will also begin on this day.

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

You can end your membership 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 plans:
  - 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.
  - If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

You get Extra Help from Medicare to pay for your prescription drugs: If you switch to Original Medicare and don't enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you've opted out of automatic enrollment.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

Section 2.3 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 also for new Medicare beneficiaries who are enrolled 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 2.4 In certain situations, you can end your membership during a Special Enrollment Period

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

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

- Usually, when you move
- If you have Medicaid
- If you're eligible for Extra Help paying for your Medicare drug coverage
- 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
- **Note:** If you're in a drug management program, you may only be eligible for certain Special Enrollment Periods. Chapter 5, Section 10 tells you more about drug management programs.
- **Note:** Section 2.1 tells you more about the special enrollment period for people with Medicaid.

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 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.
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

If you get Extra Help from Medicare to pay for your drug coverage drugs: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

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

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

Section 2.5 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Member Services at 1-800-805-2739 (TTY users call 711)**
- Find the information in the ***Medicare & You 2026*** handbook
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 3 How to end your membership in our plan

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. • 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. • You'll automatically be disenrolled from our plan when your new drug plan's coverage starts.
Original Medicare *without* a separate Medicare drug plan	• **Send us a written request to disenroll.** Call Member Services at 1-800-805-2739 (TTY users call 711) if you need more information on how to do this. • 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. • You'll be disenrolled from our plan when your coverage in Original Medicare starts.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your Kaiser Permanente QUEST benefits, contact Kaiser Permanente's QUEST customer service at 808-432-5330 or toll free at 1-800-651-2237 (TTY 711), 7 days a week, 7:45 a.m. to 8 p.m. Ask how joining another plan or returning to Original Medicare affects how you get your QUEST coverage.

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

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

- **Continue to use our network providers to get medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**

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

SECTION 5 We must end our plan membership in certain situations

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

- If you no longer have Medicare Part A and Part B.
- If you're no longer eligible for Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Medicaid.
- If you're no longer eligible for Medicaid, we will tell you in writing that you have a 180-day grace period to regain Medicaid eligibility before you are required to leave the Kaiser Permanente Dual Complete plan. Prior to termination of your enrollment in the Kaiser Permanente Dual Complete plan, we will contact you to give you the opportunity to enroll in one of our other Medicare Advantage plans. The benefits and out-of-pocket costs in these plans may differ from your benefits and out-of-pocket costs in the Kaiser Permanente Dual Complete plan. If you lose your Medicaid benefits, within our plan's six-month period of deemed continued eligibility, we'll continue to provide all Medicare Advantage plan–covered benefits. However, your cost-sharing for Medicare-covered services will change as described in the Benefits Chart.
- 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 1-800-805-2739 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or lawfully present in the United States
- If you lie or withhold information about other insurance, you have that provides drug coverage
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)

- If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

If you have questions or want more information on when we can end your membership, call Member Services at 1-800-805-2739 (TTY users call 711).

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

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

What should you do if this happens?

If you feel 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 11: Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

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

If you have a disability and need help with access to care, call Member Services at 1-800-805-2739 (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 isn't the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Kaiser Permanente Dual Complete, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4 Administration of this *Evidence of Coverage*

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

SECTION 5 Applications and statements

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

SECTION 6 Assignment

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

SECTION 7 Attorney and advocate fees and expenses

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

SECTION 8 Coordination of benefits

As described in Chapter 1, Section 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 Dual Complete 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
Patient Financial Services Department
Insurance Follow-up Manager
711 Kapiolani Blvd.
Honolulu, HI 96813

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.

SECTION 20 Binding arbitration

The following description of binding arbitration applies to the following members:

- All members enrolled in a Kaiser Permanente Medicare Advantage Individual Plan with an effective date prior to January 1, 2008; and
- All members enrolled in a Kaiser Permanente Medicare Advantage Individual Plan with an effective date of January 1, 2008 or after who have not expressly opted out of the binding arbitration process by submitting the Arbitration Opt-Out Notice mailed to you with your identification card.

Except as provided in this chapter or by applicable law, any and all claims, disputes, or causes of action arising out of or related to this *Evidence of Coverage*, its performance or alleged breach, or the relationship or conduct of the parties, including but not limited to any and all claims, disputes, or causes of action based on contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration.

By enrolling in a Kaiser Permanente Medicare Advantage plan, you waive all rights to have these types of claims decided in a court of law. The arbitrator's decision is binding.

This includes but is not limited to any claim asserted:

1. By or against a Member, a patient, the heirs or the personal representative of the estate of the Member or patient, or any other person entitled to bring an action for damages, arising from or related to harm to the member or patient as permitted by applicable federal or Hawaii state law existing at the time the claim is filed ("Member Parties"). For purposes of this agreement, all family members of the member or patient who have derivative claims arising from such harm, shall also be deemed "Member Parties" and bound to these arbitration terms;
2. On account of death, bodily injury, physical ailment, mental disturbance, or economic loss arising out of the rendering or failure to render medical services or the provision or failure to provide benefits under this agreement, except when binding arbitration is explicitly not permitted by applicable law, premises liability, or arising out of any other claim of any nature, irrespective of the legal theory upon which the claim is asserted; and
3. By or against one or more of the following entities or their employees, officers or directors ("Kaiser Permanente Parties"):
    - Kaiser Foundation Health Plan, Inc.,
    - Kaiser Foundation Hospitals,
    - Hawaii Permanente Medical Group, Inc.,
    - The Permanente Federation, LLC,

- Any individual or organization that contracts with an organization named above to provide medical services to Health Plan Members, when such contract includes a provision requiring arbitration of the claim made.

Notwithstanding any provisions to the contrary in this agreement, the following claims shall not be subject to mandatory arbitration:

- claims for monetary damages within the jurisdictional limit of the Small Claims Division of the District Courts of the State of Hawaii;
- actions for appointment of a legal guardian of a person or property subject to probate laws;
- purely injunctive orders reasonably necessary to protect Kaiser Permanente's ability to safely render medical services under this *Evidence of Coverage* (such as temporary restraining orders, and emergency court orders);
- claims that may not be subject to binding arbitration under applicable federal or state law;
- for Medicare members, claims subject to the Medicare appeals process.

Initiating arbitration

A demand for arbitration shall be initiated by sending a registered or certified letter to each named party against whom the claim is made, with a notice of the existence and nature of the claim, the amount claimed and a demand for arbitration. Any Kaiser Permanente Parties shall be served by registered or certified letter, postage prepaid, addressed to the Kaiser Permanente Parties in care of the Health Plan at Kaiser Foundation Health Plan, Inc., Member Services, 711 Kapiolani Boulevard, Honolulu, HI 96813. The arbitrators shall have jurisdiction only over persons and entities actually served.

Arbitration proceedings

Within 30 days after the service of the demand for arbitration, the parties shall agree on a panel of arbitrators from which to select arbitrators or shall agree on particular arbitrators who shall serve for the case. If the parties cannot agree on any panel of arbitrators or particular arbitrators within the 30 days, then the panel of arbitrators shall be that of Dispute Prevention and Resolution, Inc. ("DPR"). Unless the parties agree to any other arbitration service and rules, DPR shall administer the arbitration and its arbitration rules shall govern the arbitration (including rules for selection of arbitrators from a panel of arbitrators, if the parties have not already agreed upon particular arbitrators to serve). Kaiser Permanente shall notify DPR (or such other arbitration service as may be chosen by the parties) of the arbitration within 15 days following the expiration of the 30-day period noted above.

Within 30 calendar days after notice to DPR, the parties shall select a panel of three arbitrators from a list submitted to them by the arbitration service. In all claims seeking a total monetary recovery less than $25,000.00, and in any other case where the parties mutually agree, a panel of one arbitrator selected by both parties from a list submitted to them by the arbitration service will be allowed. The arbitrator(s) will arrange to hold a hearing in Honolulu (or such other location as agreed by the parties) within a reasonable time thereafter.

Limited civil discovery shall be permitted only for production of documents that are relevant and material, taking of brief depositions of treating physicians, expert witnesses and parties (a corporate party shall designate the person to be deposed on behalf of the corporation), and a maximum of three other critical witnesses for each side (i.e., respondents or claimants), and independent medical evaluations.

The arbitrator(s) will resolve any discovery disputes submitted by any party, including entry of protective orders or other discovery orders as appropriate to protect the parties' rights under this paragraph.

Any payment for the fees and expenses of the arbitration service and the arbitrator(s) shall be borne one-third by the Member Parties and two-thirds by the Kaiser Permanente Parties. Each party shall bear their own attorney's fees, witness fees, and discovery costs.

The arbitrator(s) may decide a request for summary disposition of a claim or particular issue, upon request of one party to the proceeding with notice to all other parties and a reasonable opportunity for the other parties to respond. The standards applicable to such request shall be those applicable to analogous motions for summary judgment or dismissal under the Federal Rules of Civil Procedure.

In claims involving benefits and coverage due under this agreement or disputes involving operation of the Plan, Health Plan's determinations and interpretations, and its decisions on these matters are subject to de novo review. The arbitration award shall be final and binding. The Member Parties and Kaiser Permanente Parties waive their rights to jury or court trial. With respect to any matter not expressly provided for herein, the arbitration will be governed by the Federal Arbitration Act, 9 U.S.C. Chapter 1.

General provisions

All claims based upon the same incident, transaction or related circumstances regarding the same Member or same patient shall be arbitrated in one proceeding (for example, all Member Parties asserting claims arising from an injury to the same Health Plan Member, shall be arbitrated in one proceeding).

A claim for arbitration shall be waived and forever barred if on the date notice thereof is received, the claim, if it were then asserted in a civil action, would be barred by the applicable

Hawaii statute of limitations. All notices or other papers required to be served or convenient in the conduct of arbitration proceedings following the initial service shall be mailed, postage prepaid, to such address as each party gives for this purpose. If the Federal Arbitration Act or other law applicable to these arbitration terms is deemed to prohibit any term in this agreement in any particular case, then such term(s) shall be severable in that case and the remainder of this agreement shall not be affected thereby. Class actions and consolidation of parties asserting claims regarding multiple members or patients are prohibited. The arbitration provisions in this agreement shall supersede those in any prior agreement.

Arbitration confidentiality

This *Evidence of Coverage* concerns personal medical information whose confidentiality is protected by law. Neither party nor the arbitrator(s) may disclose the substance of the arbitration proceedings or award, except as required by law or as necessary to file a motion regarding the award pursuant to the Federal Arbitration Act, in any federal or state court of appropriate jurisdiction within Hawaii, and in that event, the parties shall take all appropriate action to request that the records of the arbitration be submitted to the court under seal.

Special claims

Medical Malpractice Claims:

Prior to initiating any arbitration proceedings alleging medical malpractice, Member Parties shall first submit the claim to a Medical Inquiry and Conciliation Panel pursuant to Chapter 671, Hawaii Revised Statutes, Sections 11–19. Following the rendering of an advisory decision by the Medical Inquiry and Conciliation Panel, if the claim has not been withdrawn or settled, Member Parties shall serve a demand for arbitration on Kaiser Permanente Parties as specified in the “Initiating arbitration” section.

Benefit Claims:

If the Member Party has a claim for benefits that is denied or ignored (in whole or in part), the Member Party may pursue legal action in federal or state court, as appropriate, after the Member Party has exhausted the claims and appeals process and, if applicable, external review process. The court will decide who should pay court costs and legal fees. If the Member Party is successful, the court may order the person or entity the Member Party has sued to pay these costs and fees. If the Member Party loses, the court may order the Member Party to pay these costs and fees, for example, if it finds the Member Party’s claim is frivolous. If the Member Party has any questions about the Member Party’s plan, the Member Party should contact Health Plan at 1-800-966-5955. Although benefit-related claims may not be required to be resolved by binding arbitration pursuant to this section, Member Parties may still make a voluntary election to use binding arbitration to resolve these claims, instead of court trial, by filing a demand for arbitration upon Kaiser Permanente Parties pursuant to the provisions of the “Initiating arbitration” section. If a voluntary election to use binding

arbitration is made by a Member Party, the arbitration shall be conducted pursuant to this Section 20 and Chapter 9.

External Appeal of Internal Review Decisions:

If you disagree with Kaiser Permanente's final internal benefit determination, you may request voluntary binding arbitration pursuant to the procedures in this agreement. In addition to the arbitration procedures set forth in this agreement which may be elected by the Member (but are not mandatory), Hawaii Revised Statutes Chapter 432E also creates certain external review rights for Members to submit a request for external review to the State Insurance Commissioner within 130 days from the date of Kaiser's final internal determination. These rights are subject to the limitations noted in the next paragraph, and are subject to the requirements and limitations in Hawaii Revised Statutes Chapter 432E (including exhausting all of Kaiser Permanente's internal complaint and appeals procedures before requesting external review, except as specified in Chapter 432E for situations when simultaneous external review is permitted to occur or Kaiser Permanente has failed to comply with federal requirements regarding its claims and appeals process). A complete description of Kaiser Permanente's claims and appeals process is described in Chapter 9.

Chapter 432E external reviews are limited to situations where (a) the complaint is not for allegations of medical malpractice, professional negligence or other professional fault by health care providers, and (b) the complaint relates to an adverse action as defined in Hawaii Revised Statutes Chapter 432E. Health Plan may object to external reviews under Chapter 432E which do not meet the standards for external review under applicable federal and state law and Health Plan reserves its full rights and remedies in this regard. The recitation of state law provisions shall not be deemed to constitute any waiver of such objections.

Kaiser Permanente Medicare Advantage Member Claims:

Complaints and appeals procedures are described in Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" of this document. The arbitration provisions of this agreement apply only to Kaiser Permanente Medicare Advantage Member claims asserted on account of medical malpractice or a violation of a legal duty arising out of this agreement, irrespective of the legal theory upon which the claim is asserted.

CHAPTER 12: Definitions

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

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

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

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

Benefit Period – The way that both our plan and Original Medicare measures 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 received any inpatient hospital care or 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's no limit to the number of benefit periods.

Biological Product – A prescription drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (go to "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (go to "**Interchangeable Biosimilar**").

Brand Name Drug – A prescription drug that's manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,100 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs.

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

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

Complaint — The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Formulary (Formulary or Drug List) – A list of prescription drugs covered by our plan.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Coordination of Benefits (COB) – Coordination of Benefits is a provision used to establish the order in which claims are paid when you have other insurance. If you have Medicare and other health insurance or coverage, each type of coverage is called a payer. When there is more than one payer, there are coordination of benefits rules that decide which one pays first. The primary payer pays what it owes on your bills first, and then sends the rest to the secondary payer to pay. If payment owed to us is sent directly to you, you're required under Medicare law to give the payment to us. In some cases, there may also be a third payer. See Chapter 1, Section 7 and Chapter 11, Section 8 for more information.

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

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

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all the drugs covered by our plan.

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

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

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

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in our plan is 30 days, then your daily cost-sharing rate is $1 per day.

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

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

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some or all 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's 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's quickly getting worse.

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

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

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

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

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

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction (a formulary exception).

Excluded Drug – A drug that's not a covered Part D drug, as defined under 42 U.S.C. Section 1395w-102(e).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that's approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

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

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 house keepers, food service arrangements, or full-time nursing care at home.

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue

to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

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

Income Related Monthly Adjustment Amount (IRMAA) –If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

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

Integrated D-SNP – A D-SNP that covers Medicare and most or all Medicaid services under a single health plan for certain groups of people eligible for both Medicare and Medicaid. These people are also known as full-benefit dually eligible people.

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

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

Integrated 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.

Kaiser Foundation Health Plan (Health Plan) – Kaiser Foundation Health Plan, Inc., Hawaii Region, is a nonprofit corporation and a Medicare Advantage organization. This *Evidence of Coverage* sometimes refers to Health Plan as "we" or "us."

Kaiser Foundation Hospital – A network hospital owned and operated by Kaiser Foundation Hospitals.

Kaiser Permanente – Health Plan, Medical Group and Kaiser Foundation Hospitals.

Kaiser Permanente Region (Region) – A Kaiser Foundation Health Plan organization that conducts a direct-service health care program. When you'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.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for Medicare Part A and Part B premiums, and prescription drugs don't count toward the maximum out-of-pocket amount. (**Note:** Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum.)

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

Medical Care or Services – Health care services or items. Some examples of health care items include durable medical equipment, eyeglasses, and drugs covered by Medicare Part A or Part B, but not drugs covered under Medicare Part D.

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

Medically Accepted Indication – A use of a drug that's either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

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

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

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel its 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**.

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

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

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

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

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

Network Pharmacy –A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they're filled at one of our network pharmacies.

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

Network Provider – Provider is the general term for doctors, other health care professionals, 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.

Original Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (**Traditional Medicare or Fee-for-Service Medicare**) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved

amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply (see Chapter 5, Section 2.4, for more information).

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

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

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

Part C – Go to Medicare Advantage (MA) plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that's expected to pay, on average, at least as much as standard Medicare drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable drug coverage.

Plan – Kaiser Permanente Dual Complete.

Plan Charges – Plan Charges means the following:

- For services provided by Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for services provided to members.
- For services for which a provider (other than Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider.

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

Post-Stabilization Care – Medically necessary services related to your emergency medical condition that you receive after your treating physician determines that this condition is clinically stable. You'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 received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

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

Preventive services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

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

Prior Authorization –Approval in advance to get services or certain drugs 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. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

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

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

"Real-Time Benefit Tool" – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

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

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

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

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

The Hawaii Region's service area is described in Chapter 1, Section 2.2. For the purposes of premiums, cost-sharing, enrollment, and disenrollment, there are multiple Kaiser Permanente Dual Complete plans in our Region's service area. But, for the purposes of obtaining covered services, you get care from network providers anywhere inside our Region's service area.

Services – Health care services, supplies, or items.

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

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

Specialty Tier Drugs – Very high-cost drugs approved by the FDA that are on our formulary.

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.

NONDISCRIMINATION NOTICE

Kaiser Permanente complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat people differently or less favorably because of:

- Race
- Color
- National Origin (including limited English proficiency and primary language)
- Age
- Disability
- Sex

Kaiser Permanente provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, braille, accessible electronic formats, other formats)

Kaiser Permanente provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact **808-432-5330**, toll-free **1-800-651-2237** or by TTY **711**

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way, you can file a grievance with: Kaiser Civil Rights Coordinator, 711 Kapiolani Blvd., Honolulu, HI 96813. Phone: **808-432-5330** or toll-free **1-800-651-2237;** TTY: **711;** Fax: **808-432-5300;** Email: civil-rights-coordinator@kp.org.

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Kaiser Permanente Civil Rights Coordinator is available to help you.

This notice is available at Noticehttps://healthy.kaiserpermanente.org/hawaii/language-assistance/nondiscrimination-notice/medicaid

You can also file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201; **1-800-368-1019**,**1-800-537-7697** (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

HELP IN YOUR LANGUAGE

(English) Do you need help in another language? Language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-651-2237** to tell us which language you speak. (TTY: **711**).
(Cantonese) 您需要其他语言帮助吗？我们免费为您提供语言援助服务，包括适当的辅助工具和服务。请致电 **1-800-651-2237** 告知我们您说什么语言。 (TTY: **711**).
(Chuukese) En mi nit aninis non pwan och fosun fonu? Mi kawor aninisin fosun fonu me ekoch pisekin aninis, ese kamo, mi kawor ngonuk. Kekeri **1-800-651-2237** ka ereni kich meni fosun fonu ke kan fos non. (TTY: **711**).
(French) Avez-vous besoin d'aide dans une autre langue ? Des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-651-2237** pour nous dire quelle langue vous parlez. (TTY: **711**).
(German) Benötigen Sie Hilfe in einer anderen Sprache? Die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen steht Ihnen kostenfrei zur Verfügung. Rufen Sie **1-800-651-2237** an, um uns mitzuteilen, welche Sprache Sie sprechen. (TTY: **711**).
(Hawaiian) Loaʻa iā ʻoe nā lawelawe kōkua ʻōlelo me nā kōkua kōkua a me nā lawelawe me ka uku ʻole. Kāhea **1-800-651-2237** oe ia la kaua a e ha`ina `oe ia la maua mea `olelo o na `aina `e. (TTY: **711**).
(Ilocano) Kasapulam kadi ti tulong iti sabali a pagsasao? Dagiti serbisio a tulong iti pagsasao agraman dagiti maitutop a kanayonan a tulong ken serbisio, a libre, ket mabalin a mausar para kenka. Tawagan ti **1-800-651-2237** tapno maibagam kadakami no ania a pagsasao ti pagsasaom. (TTY: **711**).
(Japanese) 他の言語でのサポートが必要ですか？適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-800-651-2237** にお電話いただき、使用される言語をお知らせください。（TTY：**711**）。
(Korean) 다른 언어로 도움이 필요하신가요? 언어 지원 서비스는 필요에 따라 보조 기기 및 서비스를 포함하여 무료로 제공됩니다. 도움이 필요한 언어를 알려주시려면 **1-800-651-2237** 로 전화해 주세요. （TTY：**711**）.
(Mandarin) 您需要其他語言的幫助嗎？您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-651-2237** 告訴我們您說哪種語言。(TTY:**711**).
(Marshallese) Kwōj ke aikuj jipañ ilo kajin ko jet? Ro rej ropajikin jipañ eok ikijjien kajin im jerbal ko jet repojakin jerbal ippaṃ ilo ejjeḷọk oṇaer. Kūr tok **1-800-651-2237** ñan kaaroñ tok kōm kōn kajin eo aṃ. (TTY: **711**).
(Samoan) O lo'o e mana'omia se fesoasoani i se isi gagana? O auaunaga fesoasoani i le gagana, e aofia ai meafaigaluega talafeagai ma auaunaga, e leai ni totogi, o lo'o avanoa mo oe. Fa'amalie atu i le **1-800-651-2237** ma ta'u mai i matou le gagana e te tautala ai. (TTY: **711**).
(Spanish) ¿Necesita ayuda en otro idioma? Tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-651-2237** para que nos indique el idioma que habla. (TTY: **711**).
(Tagalog) Kailangan mo ba ng tulong sa ibang wika? Available sa iyo ang mga serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-651-2237** para sabihin sa amin kung aling wika ang sinasalita mo. (TTY: **711**).
(Tongan) ʻOku ke toe fiemaʻu ha tokoni ʻi ha lea kehe? ʻOku ʻi ai ha sevesi tokoni fakatonu lea pea mo ha naunau meʻa fanongo, ʻoku taʻetotongi, mo faingamalie kiate koe. Taa **1-800-651-2237** pea talamai ʻa e lea ʻoku ke fakaʻaongaʻi. (TTY:**711**).

(Vietnamese) Bạn có cần trợ giúp bằng ngôn ngữ khác không? Bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-651-2237** để cho chúng tôi biết ngôn ngữ bạn nói. (TTY: **711**).
(Visayan) Nanginahanglan ka ba og tabang sa laing pinulongan? Ang mga serbisyo sa tabang sa pinulongan lakip ang angay nga mga auxiliary nga mga himan ug serbisyo, libre, anaa kanimo. Tawag sa **1-800-651-2237** aron isulti kanamo kung unsang pinulongan ang imong ginasulti. (TTY: **711**).

KAISER PERMANENTE®

Kaiser Permanente Dual Complete Member Services

Method	Member Services – Contact Information
Call	1-800-805-2739 Calls to this number are free. 7 days a week, 7:45 a.m. to 8 p.m. Member Services 1-800-805-2739 (TTY users call 711) also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 7:45 a.m. to 8 p.m.
Write	Kaiser Permanente Member Services 711 Kapiolani Blvd. Honolulu, HI 96813
Website	kp.org

State Health Insurance Assistance Program

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

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