

January 1 – December 31, 2027

Evidence of Coverage for 2027:

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

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

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

- Your plan premium and cost-sharing
- Your medical 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 1-800-232-4404 (TTY users call 711). Hours are 8 a.m. to 8 p.m., 7 days a week. This call is free.

This plan, Kaiser Permanente Senior Advantage, is offered by Kaiser Foundation Health Plan of Georgia, 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 Senior Advantage (Senior Advantage).

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

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

Our 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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CHAPTER 1:

Get started as a member

SECTION 1 You're a member of Kaiser Permanente Senior Advantage

Section 1.1 You're enrolled in Kaiser Permanente Senior Advantage, which is a Medicare HMO

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

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

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

- Kaiser Permanente Senior Advantage Basic 1 (HMO)–referred to in this document as the “**Basic 1 plan.**”
- Kaiser Permanente Senior Advantage Enhanced 1 (HMO)–referred to in this document as the “**Enhanced 1 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 Changes* (or for new members, your enrollment form or enrollment confirmation letter).

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 *2027 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 Senior Advantage between January 1, 2027, and December 31, 2027.

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, 2027. We can also choose to stop offering our plan in your service area, after December 31, 2027.

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

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

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

- You have both Medicare Part A and Medicare Part B.
- You live in our geographic service area (described in Section 2.2). If you've been a member of our plan continuously since before January 1999 and you were living outside our service area before January 1999, you're still eligible for our plan as long as you haven't moved since before January 1999. People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it.
- You're a United States citizen or national, or an eligible noncitizen.

Section 2.2 Plan service area for Kaiser Permanente Senior Advantage

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

Our service area includes these counties in Georgia: **Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, and Henry**. Also, our service area includes these parts of **Paulding County in Georgia, in the following ZIP codes only:** 30127, 30134, and 30141.

If you move out of our plan's service area, you can't stay a member of this plan. Call Member Services at 1-800-232-4404 (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 2.3 U.S. citizen or national, or eligible noncitizen

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

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

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



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

If our plan membership card is damaged, lost, or stolen, call Member Services at 1-800-232-4404 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider Directory

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

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

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

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

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Member Services at 1-800-232-4404 (TTY users call 711). Requested paper provider directories will be mailed to you within 3 business days.

Section 3.3 Pharmacy Directory

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

If you don't have a *Pharmacy Directory*, you can ask for a copy from Member Services at 1-800-232-4404 (TTY users call 711). You can also find this information on our website at kp.org/directory.

Section 3.4 Drug List (formulary)

Our plan has a *2027 Comprehensive Formulary* (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit included in our plan. The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List meets all Medicare requirements. Drugs included in the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed or 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 1-800-232-4404 (TTY users call 711).

SECTION 4 Summary of Important Costs for 2027

	Your Costs in 2027
Monthly plan premium* * Your premium can be higher or lower than this amount. Go to Section 4.1 for details.	• Basic 1 - \$0 • Enhanced 1 - \$70
Maximum out-of-pocket amount	• Basic 1 - \$8,450 • Enhanced 1 - \$7,000

	Your Costs in 2027
This is the <u>most</u> you'll pay out-of-pocket for covered Part A and Part B services. (Go to Chapter 4, Section 1.2 for details.)	
Primary care office visits	You pay the following per primary care visit, depending upon the plan in which you are enrolled: • Basic 1 - \$0 • Enhanced 1 - \$0
Specialist office visits	You pay the following per specialty care visit, depending upon the plan in which you are enrolled: • Basic 1 - \$0-\$35 • Enhanced 1 - \$0-\$25
Inpatient hospital stays Includes various inpatient hospital stays such as acute care rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	Cost-sharing is charged for each inpatient stay. You pay the following per day for days 1–6, depending upon the plan in which you are enrolled: • Basic 1 - \$407 • Enhanced 1 - \$350 Thereafter, you pay \$0 for the rest of your stay.
Part D drug coverage (Go to Chapter 6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Part D drug coverage deductible • Basic 1 – \$0 • Enhanced 1 – \$0 Cost-sharing during the Initial Coverage Stage (up to a 30-day supply):

Your Costs in 2027

Drug Tier 1:

- **Basic 1 – \$0**
- **Enhanced 1 – \$0**

Drug Tier 2:

- **Basic 1 – \$0**
- **Enhanced 1 – \$0**

Drug Tier 3:

- **Basic 1 – \$47**
- **Enhanced 1 – \$47**

You pay no more than \$35 per month supply of each covered insulin product on this tier.

Drug Tier 4:

- **Basic 1 – \$100**
- **Enhanced 1 – \$100**

You pay no more than \$35 per month supply of each covered insulin product on this tier.

Drug Tier 5:

- **Basic 1 – 30%**
- **Enhanced 1 – 32%**

You pay no more than \$35 per month supply of each covered insulin product on this tier.

Drug Tier 6:

- **Basic 1 – \$0**
- **Enhanced 1 – \$0**

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)
- Optional Supplemental Benefits Premium (Section 4.3)
- Part D Late Enrollment Penalty (Section 4.4)
- Income Related Monthly Adjusted Amount (Section 4.5)
- Medicare Prescription Payment Plan Amount (Section 4.6)

Section 4.1 Plan premium

As a member of our plan, you pay a monthly plan premium. The table below shows the monthly plan premium amount for each plan we offer in the service area.

Plan Name	Plan Premium
Basic 1 plan	\$0
Enhanced 1 plan	\$70

If you signed up for extra benefits, also called “**optional supplemental benefits**”, then you pay an additional premium each month for these extra benefits. See Section 4.3 in this chapter for details.

In some situations, your plan premium could be less

There are programs to help people with limited resources pay for their drugs. The Extra Help program helps people with limited resources pay for their drugs. Learn more about this program in Chapter 2, Section 7. If you qualify, enrolling in this program might lower your monthly plan premium.

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

If you *already* get help from one of these programs, **the information about premiums in this Evidence of Coverage does not apply to you**. We sent you a separate document, 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 1-800-232-4404 (TTY users call 711) and ask for the *LIS Rider*.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

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

Section 4.3 Optional Supplemental Benefits Premium

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

The monthly premium for optional supplemental benefits (Advantage Plus) is **\$13**.

Section 4.4 Part D Late Enrollment Penalty

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

The Part D late enrollment penalty is added to your monthly premium. When you first enroll in our plan, we let you know the amount of the penalty.

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 Part D or other creditable coverage.
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or in a newsletter from that plan. Keep this information because you may need it if you join a Medicare drug plan later.
 - **Note:** Any letter or notice must state that you had creditable prescription drug coverage that's expected to pay as much as Medicare's standard drug plan pays.

- **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

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

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, our plan will count the number of full months you didn't have coverage.
- 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 2027, this average premium amount is \$41.33.
- To calculate your monthly penalty, Medicare multiplies the number of uncovered months (penalty percentage) by 1% of the national base beneficiary premium and then rounds that amount to the nearest 10 cents. For example, if you go 14 months without Part D or other creditable coverage, the penalty would be 14% times \$41.33, which equals \$5.78. This rounds to \$5.80. 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 generally continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're *under* 65 and enrolled in Medicare, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a reconsideration (appeal) of the penalty. The reconsideration is conducted by an independent review organization that is not connected with us. Generally, you must ask for this reconsideration **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 generally won't have another chance to ask for a reconsideration of that late enrollment penalty.

Section 4.5 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified

adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit [Medicare.gov/health-drug-plans/part-d/basics/costs](https://www.medicare.gov/health-drug-plans/part-d/basics/costs).

If you have to pay an extra IRMAA, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your 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 4.6 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay your 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 How to pay your plan premium

There are 4 ways you can pay your plan premium.

Option 1: Pay by check

You may pay by check and mail your monthly plan premium directly to us. We must receive your check (or money order) made payable to "Kaiser Permanente" on or before the last day of the month preceding the month of coverage at the following address, or the address on your invoice if it's different:

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

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

Option 2: You can sign up for monthly automatic payment

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

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

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

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

You can make a one-time payment by credit or debit card online at kp.org/payonline or by calling 1-877-699-7407, 7 days a week, 24 hours a day. You will need your Kaiser Permanente account information from your bill to make a payment.

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

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

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

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

If you have trouble paying your plan premium

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

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

If you owe a Part D late enrollment penalty, you must pay the penalty to keep your drug coverage.

If you have trouble paying your premium on time, call Member Services at 1-800-232-4404 (TTY users call 711) to see if we can direct you to programs that will help with your costs.

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

If you think we wrongfully ended your membership, you can make a complaint (also called a grievance). If you had an emergency circumstance out of your control that made you unable to pay your plan premium within our grace period, you can make a complaint. For complaints, we'll review our decision again. Go to Chapter 9 to learn how to make a complaint or call us at 1-800-232-4404 between 8 a.m. to 8 p.m., 7 days a week. TTY users call 711. You must make your complaint no later than 60 calendar days after the date your membership ends.

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

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

If you become eligible for Extra Help or lose your eligibility for Extra Help during the year, the part of your plan premium you have to pay may change. If you qualify for Extra Help with your drug coverage costs, Extra Help pays part of your monthly plan premium. If you lose your eligibility for Extra Help during the year, you'll need to start paying the full monthly plan premium. Find out more about Extra Help in Chapter 2, Section 7.

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

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

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

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

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

If any of this information changes, let us know by calling Member Services at 1-800-232-4404 (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 over this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services at 1-800-232-4404 (TTY users call 711). You may need to give your plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

Chapter 1 Get started as a member

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

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

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

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

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

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

CHAPTER 2:

Phone numbers and resources

SECTION 1 Kaiser Permanente Senior Advantage contacts

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

Member Services – Contact Information

Call	1-800-232-4404 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services at 1-800-232-4404 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
Write	Kaiser Permanente Member Services Nine Piedmont Center 3495 Piedmont Road, NE Atlanta, GA 30305-1736
Website	kp.org

How to ask for a coverage decision about your medical care

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

Coverage Decisions for Medical Care – Contact Information

Call	1-800-232-4404 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.

Coverage Decisions for Medical Care – Contact Information

Write	Kaiser Permanente Attention: Member Services Department Nine Piedmont Center 3495 Piedmont Road, NE Atlanta, GA 30305-1736
Website	kp.org

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

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

Coverage Decisions for Part D Drugs – Contact Information

Call	1-888-277-3914 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 ask for 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	1-800-232-4404 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	1-404-949-5001
Write	Kaiser Permanente Attention: Member Relations Nine Piedmont Center 3495 Piedmont Road, NE Atlanta, GA 30305-1736
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	1-800-232-4404 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
TTY	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
Write	Kaiser Permanente Attention: Member Relations Nine Piedmont Center 3495 Piedmont Road, NE Atlanta, GA 30305-1736
Medicare website	To submit a complaint about our plan directly to Medicare, go to Medicare.gov/my/medicare-complaint .

How to ask us to pay our share of the cost for medical care 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	1-404-261-2825 Calls to this number are not free. Monday through Friday, 8:30 a.m. to 5 p.m.
TTY	711 Calls to this number are free. Monday through Friday, 8:30 a.m. to 5 p.m.
Write	Kaiser Permanente Claims Department P.O. Box 370010 Denver, CO 80237-9998
Website	kp.org

SECTION 2 Get help from Medicare

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

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

Medicare – Contact Information

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

SECTION 3 State Health Insurance Assistance Program (SHIP)

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

Georgia 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.

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

Georgia SHIP – Contact Information

Call	1-866-552-4464 (select option 4 when prompted)
Write	Georgia SHIP Department of Human Resources – Division of Aging Services 2 Peachtree Street, NW, 33rd Floor Atlanta, GA 30303-3142
Website	https://aging.georgia.gov/georgia-ship

SECTION 4 Quality Improvement Organization (QIO)

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

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

Contact Acentra Health in any of these situations:

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

Acentra Health (Georgia's Quality Improvement Organization) – Contact Information

Call	1-888-317-0751 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

Acentra Health (Georgia's Quality Improvement Organization) – Contact Information

Write	Acentra Health 1650 Summit Lake Dr., Suite 102 Tallahassee, FL 32317
Website	acentraqio.com

SECTION 5 Social Security

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

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

Social Security – Contact Information

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

SECTION 6 Medicaid

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

Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

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

To find out more about Medicaid and Medicare Savings Programs, contact the office in your county shown in the table below or visit the state's Medicaid Website at dfcs.georgia.gov.

Georgia's Medicaid agencies by county – Contact Information

Cherokee County DFCS 1300 Univeter Road, Suite 100 Canton, GA 30115 Phone: 1-770-720-3610 Hours: Monday–Friday: 9 a.m. to 4 p.m.	Fulton County DFCS 5710 Stonewall Tell Road College Park, GA 30349 Phone: 1-404-206-5778 Hours: Monday–Friday: 9 a.m. to 4 p.m.
Clayton County DFCS 877 Battle Creek Road Jonesboro, GA 30236 Phone: 1-770-473-2339 Hours: Monday–Friday: 9 a.m. to 4 p.m.	Cobb County DFCS 1090 Northchase Pkwy SE, Suite 200 Marietta, GA 30060 Phone: 1-770-528-7683 Hours: Monday–Friday: 9 a.m. to 4 p.m.
Fulton County DFCS Northwest Service Center 1249 Donald Lee Hollowell Parkway Atlanta, GA 30318 Phone: 1-404-206-5778 Hours: Monday–Friday: 9 a.m. to 4 p.m.	Coweta County DFCS 533 Highway 29 North Newnan, GA 30263 Phone: 1-770-254-7234 Hours: Monday–Friday: 9 a.m. to 4 p.m.
DeKalb County DFCS 2300 Parklane Drive NE Atlanta, GA 30345 Phone: 1-404-370-5000 Hours: Monday–Friday: 9 a.m. to 4 p.m.	Gwinnett County DFCS 95 Constitution Blvd. Lawrenceville, GA 30046-2475 Phone: 1-678-518-5500 Hours: Monday–Friday: 9 a.m. to 4 p.m.

Georgia's Medicaid agencies by county – Contact Information

Douglas County DFCS

8473 Duralee Lane Suite 100
Douglasville, GA 30134
Phone: 1-770-489-3000
Hours: Monday–Friday: 9 a.m. to 4 p.m.

Henry County DFCS

125 Henry Parkway
McDonough, GA 30253-6636
Phone: 1-770-954-2014
Hours: Monday–Friday: 9 a.m. to 4 p.m.

Fayette County DFCS

905 Highway 85 South
Fayetteville, GA 30215
Phone: 1-770-460-2555
Hours: Monday–Friday: 9 a.m. to 4 p.m.

Paulding County DFCS

1387 Industrial Blvd. North, Suite 101
Dallas, GA 30132-0168
Phone: 1-770-433-7810
Hours: Monday–Friday: 9 a.m. to 4 p.m.

SECTION 7 Programs to help people pay for prescription drugs

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

Extra Help from Medicare

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

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

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

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

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

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

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

- Write to Kaiser Permanente at:
California Service Center
Attn: Best Available Evidence
P.O. Box 232407
San Diego, CA 92193-2407
- Fax it to 1-877-528-8579.
- Take it to a network pharmacy.
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make the payment directly to the state. Call Member Services at 1-800-232-4404 (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 Georgia AIDS Drug help Program.

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call 1-404-656-9805.

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 2027; you do not need to submit a new election request to continue participating in 2027.** To learn more about this payment option, call Member Services at 1-800-232-4404 (TTY users call 711) or visit [Medicare.gov](https://www.Medicare.gov).

Medicare Prescription Payment Plan – Contact Information

Call	1-800-232-4404 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services 1-800-232-4404 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
Write	Kaiser Permanente Member Services Nine Piedmont Center 3495 Piedmont Road, NE Atlanta, GA 30305-1736
Website	kp.org

SECTION 8 Railroad Retirement Board (RRB)

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

your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information

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

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

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner’s) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at 1-800-232-4404 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner’s) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

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

CHAPTER 3:

Using our plan for your medical services

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

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

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

We will generally cover your medical care as long as:

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

- In most situations, your network PCP must give you approval in advance (a referral) before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information, go to Section 2.3.
- You don't need referrals from your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2.
- **You must get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means you have to pay the provider in full for services you get. Here are 4 exceptions:
 - Our plan covers emergency 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, you pay the same as you'd pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
 - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost-sharing you pay our plan for dialysis can never be higher than the cost-sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider that's outside our plan's network, your cost-sharing can't be higher than the cost-sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost-sharing for the dialysis may be higher.
 - If you receive care from network providers in other Kaiser Permanente regions described in Section 2.4 in this chapter.

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

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

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

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

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

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

How to choose or change your PCP

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

You can change your PCP for any reason, at any time from our available PCPs, including if you need to select a new PCP because your PCP isn't part of our network of providers any longer. Your PCP selections will be effective immediately.

To choose or change your PCP, please call Member Services (phone numbers are printed on the back cover of this document) or visit kp.org.

When you call, tell us if you are seeing specialists or getting other covered services that need your PCP's approval (such as home health services and durable medical equipment) so we can tell you if you need to get a referral from your new PCP to continue the services. Also, if

there is a particular network specialist or hospital that you want to use, check with us to find out if your PCP makes referrals to that specialist or uses that hospital.

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

Section 2.2 Medical care you can get without a PCP referral

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

- Routine women's health care, including breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider
- Flu shots, COVID-19 vaccines 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 1-800-232-4404 (TTY users call 711) before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.
- Second opinions from another network Medical Group provider
- Preventive care, except for abdominal aortic aneurysm screening, bone mass measurement, cardiovascular screening blood tests, colorectal cancer screening, and medical nutrition therapy
- Mental health and behavioral health specialists, as long as you receive services from a network provider
- Ophthalmologists and optometrists, as long as you receive services from a network provider

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

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

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

Referrals from your PCP

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

Referrals to network providers

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

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

Prior authorization

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

- Services and items identified in Chapter 4 with a footnote (†).
- For certain network specialty care, your PCP will need to request that we authorize the referral before you can see the specialty care network provider. If we authorize the

referral, it will be for a specific treatment plan as explained above (see “Referrals to network providers” for details).

- If your network provider decides that you require covered services not available from network providers, he or she will recommend to Medical Group that you be referred to an out-of-network provider inside or outside our service area. The appropriate Medical Group designee will authorize the services if he or she determines that the covered services are medically necessary and are not available from a network provider. Referrals to out-of-network providers will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. It specifies the duration of the referral without having to get additional approval from us. Please ask your network provider what services have been authorized if you are not certain. If the out-of-network specialist wants you to come back for more care, be sure to check if the referral covers the additional care. If it doesn't, please contact your network provider.
- After we are notified that you need post-stabilization care from an out-of-network provider following emergency care, we will discuss your condition with the out-of-network provider. If we decide that you require post-stabilization care and that this care would be covered if you received it from a network provider, we will authorize your care from the out-of-network provider only if we cannot arrange to have a network provider (or other designated provider) provide the care. Please see Section 3.1 in this chapter for more information.
- Medically necessary transgender surgery and associated procedures.
- Medically necessary bariatric surgery.
- Care from a religious nonmedical health care institution described in Section 6 of this chapter.
- If your network provider makes a written 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. Please contact us so we can authorize medically necessary services.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 9).

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

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

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

(TTY 711), 24 hours a day, 7 days a week (except holidays), or visit our website at kp.org/travel for more information about getting care when visiting another Kaiser Permanente Region's service area, including coverage information and facility locations. **Note:** Our Care Away From Home travel line can also answer questions about covered emergency or urgent care services you receive out-of-network, including how to get reimbursement.

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

Section 3.1 Get care if you have a medical emergency

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

If you have a medical emergency:

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

Covered services in a medical emergency

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

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

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

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

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

What if it wasn't a medical emergency?

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

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

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

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

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

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

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

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

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

Section 3.3 Get care during a disaster

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

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

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

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

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

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

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

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

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

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

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

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

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

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

Section 5.2 Who pays for services in a clinical research study

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

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

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

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

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

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

Get more information about joining a clinical research study

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

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

Section 6.1 A religious non-medical health care institution

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

care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

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

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

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

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

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

Note: Covered services are subject to the same limitations and cost-sharing required for services provided by network providers as described in Chapter 4 and Chapter 12.

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of our plan, you won't get ownership**

of rented DME items no matter how many copayments you make for the item while a member of our plan. You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan.

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

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

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

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

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

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

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

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

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

CHAPTER 4:

Medical Benefits Chart

(what's covered and what you pay)

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

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of our plan. This section also gives information about medical services that aren't covered 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 2.1 in this chapter describes our optional supplemental benefits.

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

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

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

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

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

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

- **\$8,450** for Basic 1 plan members.

- **\$7,000** for Enhanced 1 plan members.

The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for plan premiums and 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 **\$8,450** for Basic 1 plan members and **\$7,000** for Enhanced 1 plan members you won't have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Providers aren't allowed to balance bill you

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

Here's how protection from balance billing works:

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

- If you think a provider has balance billed you, call Member Services at 1-800-232-4404 (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 are met:

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

Other important things to know about our coverage:

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

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay more in our plan than you would in Original Medicare. For others, you pay less. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You* 2027 handbook. View it online at [Medicare.gov](https://www.medicare.gov) or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.



This apple shows preventive services in the Medical Benefits Chart.

Important Benefit Information for Enrollees with Chronic Conditions

- If you're diagnosed with any of the chronic condition(s) listed below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.
- Chronic alcohol use disorder and other substance use disorders (SUDs)
- Autoimmune disorders:
 - Polyarteritis nodosa
 - Polymyalgia rheumatica
 - Polymyositis
 - Dermatomyositis
 - Rheumatoid arthritis
 - Systemic lupus erythematosus
 - Psoriatic arthritis
 - Scleroderma
- Cancer
- Cardiovascular disorders:
 - Cardiac arrhythmias
 - Coronary artery disease
 - Peripheral vascular disease
 - Valvular heart disease

- Chronic heart failure
- Dementia
- Diabetes mellitus
- Overweight, obesity, and metabolic syndrome
- Chronic gastrointestinal disease:
 - Chronic liver disease
 - Non-alcoholic fatty liver disease (NAFLD)
 - Hepatitis B
 - Hepatitis C
 - Pancreatitis
 - Irritable bowel syndrome
 - Inflammatory bowel disease
- Chronic kidney disease (CKD):
 - CKD requiring dialysis/End-stage renal disease (ESRD)
 - CKD not requiring dialysis
- Severe hematologic disorders:
 - Aplastic anemia
 - Hemophilia
 - Immune thrombocytopenic purpura
 - Myelodysplastic syndrome
 - Sickle-cell disease (excluding sickle-cell trait)
 - Chronic venous thromboembolic disorder
- HIV/AIDS
- Chronic lung disorders:
 - Asthma, chronic bronchitis
 - Cystic fibrosis
 - Emphysema
 - Pulmonary fibrosis
 - Pulmonary hypertension
 - Chronic Obstructive Pulmonary Disease (COPD)

- Chronic and disabling mental health conditions:
 - Bipolar disorders
 - Major depressive disorders
 - Paranoid disorder
 - Schizophrenia
 - Schizoaffective disorder
 - Post-traumatic stress disorder (PTSD)
 - Eating disorders
 - Anxiety disorders
- Neurologic disorders:
 - Amyotrophic lateral sclerosis (ALS)
 - Epilepsy
 - Extensive paralysis (that is, hemiplegia, quadriplegia, paraplegia, monoplegia)
 - Huntington's disease
 - Multiple sclerosis
 - Parkinson's disease
 - Polyneuropathy
 - Fibromyalgia
 - Chronic fatigue syndrome
 - Spinal cord injuries
 - Spinal stenosis
 - Stroke-related neurologic deficit
- Stroke
- Post-organ transplantation care
- Immunodeficiency and Immunosuppressive disorders
- Conditions associated with cognitive impairment:
 - Alzheimer's disease
 - Intellectual disabilities and developmental disabilities
 - Traumatic brain injuries
 - Disabling mental illness associated with cognitive impairment
 - Mild cognitive impairment

- Conditions with functional challenges and require similar services:
 - Spinal cord injuries
 - Paralysis
 - Limb loss
 - Stroke
 - Arthritis
- Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell
- Conditions that require continued therapy services in order for individuals to maintain or retain functioning
- To qualify for SSBCI benefits, you must meet all of the following criteria:
 - Have one or more comorbid and medically complex chronic conditions listed above that is life-threatening or that significantly limits your overall health or function, *and*
 - Have a high risk of hospitalization or other significant adverse health outcomes, *and*
 - Require intensive care coordination
- For more information on Kaiser Permanente's SSBCI policies and objective criteria, please visit our website at kp.org/medicare/SSBCI.
- You do not need to take any action. The plan will determine your eligibility through review of your medical claims history and health record to verify diagnosis of eligible chronic condition(s), high risk for hospitalization, and need for intensive care coordination.
- In select circumstances, when there may be insufficient medical claims history or health records available to determine SSBCI eligibility, such as when you are new to Kaiser Permanente, a provider may attest to your qualification by completing and submitting the Provider Attestation Form. The Provider Attestation Form may only be used to validate preliminary SSBCI eligibility for an initial benefit period of six months. Submission of the form does not guarantee eligibility for SSBCI. At the end of this preliminary period, ongoing eligibility must be verified through review of your medical claims history and health record.
- For more detail, go to the “Special Supplemental Benefits for the Chronically Ill” row in the Medical Benefits Chart below.

Contact us to find out exactly which benefits you may be eligible for.

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

The Medical Benefits Chart below describes the medical benefits of the following Kaiser Permanente (Senior Advantage) plans included in this *Evidence of Coverage*:

- Basic 1 plan.
- Enhanced 1 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 Changes* (or for new members, your enrollment form or enrollment confirmation letter).

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 (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain† 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 • Not associated with pregnancy An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:	20% coinsurance

†Your provider must obtain prior authorization from our plan.

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

Covered Service	What you pay
• a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by regulations.	
Ambulance services Covered ambulance services, whether for an emergency or non-emergency† situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. We also cover the services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) if you reasonably believe that you have an emergency medical condition and you reasonably believe that your condition requires the clinical support of ambulance transport services.	\$310 per one-way trip

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Covered Service	What you pay
 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 <i>Welcome to Medicare</i> preventive visit. However, you don't need to have had a <i>Welcome to Medicare</i> 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.
 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	There is no coinsurance, copayment, or deductible for covered screening mammograms.

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Covered Service	What you pay
Clinical breast exams once every 24 months	
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 covers these comprehensive programs if you've had at least one of these conditions: - Heart attack in the last 12 months - Coronary artery bypass surgery - Stable angina pectoris (chest pain) - Heart valve repair or replacement - Coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) - Heart or heart and lung transplant - Stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have 2 sessions per day (each lasting 1 hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.	\$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.

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Covered Service	What you pay
 Cardiovascular disease screening tests† Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
 Cervical and vaginal cancer screening Covered services include: • Pap tests and pelvic exams once every 24 months for all women • One pap test every 12 months if at high risk of cervical or vaginal cancer or if of childbearing age and have had an abnormal pap test within the past 3 years	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct a vertebral subluxation ○ These Medicare-covered services are provided by a network chiropractor. For the list of network chiropractors, please refer to the <i>Provider Directory</i>	20% coinsurance
 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.	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

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Covered Service	What you pay
• Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, coverage of a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • 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. • 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	exam becomes a diagnostic exam and you pay \$0.

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Covered Service	What you pay
of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
- Procedures performed during a screening colonoscopy (for example, removal of polyps). - Colonoscopies following a positive gFOBT or FIT test or a flexible sigmoidoscopy screening. Note: All other colonoscopies are subject to the applicable cost-sharing listed elsewhere in this chart.	\$0
Dental services - Medicare In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation.	You pay the following per visit, depending upon the plan in which you are enrolled: \$35 for Basic 1 plan members. \$25 for Enhanced 1 plan members.
Dental services (preventive and comprehensive) – not covered by Medicare* We cover certain preventive and comprehensive dental care described below through our agreement with Delta Dental Insurance Company ("Delta Dental") and its DeltaCare USA Medicare Plan through a network of dentists that contract with Delta Dental to provide dental services. For information about dental providers, please refer to the DeltaCare USA Medicare network "Find a dentist" page by visiting kp.org/dental/ga/medicare.	

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Covered Service	What you pay
For services to be covered, members must receive dental care from their selected DeltaCare USA Medicare dentist. If a procedure isn't listed below, it isn't covered. You should discuss all treatment options with your selected dentist or dental specialist prior to receiving services. A referral may be required if a specialist is needed for your treatment plan. You may select or change your selected dentist using your online account or contacting the Delta Dental Customer Service Center at 1-844-519-8693, Monday through Friday, 8 a.m. to 8 p.m.; October 1 – March 31, 8 a.m. to 8 p.m., 7 days a week (TTY users should call 711). A change to your selected dentist made by the 15th of the month is effective immediately. Selections made on or after the 16th of the month will be effective on the first day of the following month. To make an appointment: • Call your selected dentist's facility and identify yourself as a DeltaCare USA Medicare plan member. • You can learn more about your selected dentist or select a new dentist online by visiting kp.org/dental/ga/medicare. Except for emergency services, you must go to a selected contracted dentist to obtain covered services. Any other treatment is not covered under your dental benefit. If treatment, including services provided by a specialist, are recommended, ask your dentist to submit a treatment plan to Delta Dental for review. Delta Dental will provide both you and your dentist with an estimate of the expected costs, helping you better understand your coverage and anticipated out-of-pocket expenses before services are performed.	

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Covered Service	What you pay
Diagnostic Services (D0100-D0999)	
Full mouth X-rays and radiographic images (D0210) are limited to one set every 2 calendar years and include any combination of periapicals (D0220, D0230) and bitewings (D0270, D0272, D0273, D0274, D0277). Benefits are limited to either an intraoral complete series radiographic images (D0210) or panoramic radiographic image (D0330) within two calendar years. Panoramic images are not considered part of a comprehensive intraoral series.	
D0120 - Periodic oral evaluation <i>Two oral evaluations (D0120, D0140, D0160 or D0170) every calendar year</i>	\$0
D0140 - Limited oral evaluation - problem focused <i>Two oral evaluations (D0120, D0140, D0160 or D0170) every calendar year</i>	\$0
D0150 - Comprehensive oral evaluation - new or established patient <i>One comprehensive evaluation (D0150 or D0180) every 3 calendar years per provider or location</i>	\$0
D0160 - Detailed and extensive oral evaluation - problem focused, by report <i>Two oral evaluations (D0120, D0140, D0160 or D0170) every calendar year</i>	\$0
D0170 - Re-evaluation - limited, problem focused (established patient; not post-operative visit) <i>Two oral evaluations (D0120, D0140, D0160 or D0170) every calendar year</i>	\$0
D0171 - Re-evaluation - post-operative office visit	\$0
D0180 - Comprehensive periodontal evaluation - new or established patient <i>One comprehensive evaluation (D0150 or D0180) every 3 calendar years per provider or location</i>	\$0
D0190 - Screening of a patient <i>One (D0190 or D0191) every calendar year</i>	\$0

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Covered Service	What you pay
D0191 - Assessment of a patient <i>One (D0190 or D0191) every calendar year</i>	\$0
D0210 - Intraoral - comprehensive series of radiographic images <i>One (D0210 or D0330) every 2 calendar years</i>	\$0
D0220 - Intraoral - periapical first radiographic image <i>Two periapicals (D0220 or D0230) every calendar year</i>	\$0
D0230 - Intraoral - periapical each additional radiographic image <i>Two periapicals (D0220 or D0230) every calendar year</i>	\$0
D0270 - Bitewing - single radiographic image <i>One set of bitewing X-rays (D0270, D0272, D0273, D0274 or D0277) every calendar year</i>	\$0
D0272 - Bitewings - two radiographic images <i>One set of bitewing X-rays (D0270, D0272, D0273, D0274 or D0277) every calendar year</i>	\$0
D0273 - Bitewings - three radiographic images <i>One set of bitewing X-rays (D0270, D0272, D0273, D0274 or D0277) every calendar year</i>	\$0
D0274 - Bitewings - four radiographic images <i>One set of bitewing X-rays (D0270, D0272, D0273, D0274 or D0277) every calendar year</i>	\$0
D0277 - Vertical bitewings - 7 to 8 radiographic images <i>One set of bitewing X-rays (D0270, D0272, D0273, D0274 or D0277) every calendar year</i>	\$0
D0330 - Panoramic radiographic image <i>One (D0210 or D0330) every 2 calendar years</i>	\$0

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Covered Service	What you pay
D0350 - 2D oral/facial photographic image obtained intra-orally or extra-orally <i>One every 3 calendar years</i>	\$0
D0396 - 3D printing of a 3D dental surface scan	\$0
D0419 - Assessment of salivary flow by measurement <i>One every 2 calendar years</i>	\$0
D0460 - Pulp vitality test <i>One every 2 calendar years</i>	\$0
D0461 - Testing for cracked tooth	\$0
D0600 - Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum	\$0
D0601 - Caries risk assessment and documentation, with a finding of low risk <i>One (D0601, D0602 or D0603) every 2 calendar years</i>	\$0
D0602 - Caries risk assessment and documentation, with a finding of moderate risk <i>One (D0601, D0602 or D0603) every 2 calendar years</i>	\$0
D0603 - Caries risk assessment and documentation, with a finding of high risk <i>One (D0601, D0602 or D0603) every 2 calendar years</i>	\$0
D0701 - Panoramic radiographic image – image capture only	\$0
D0702 - 2-D cephalometric radiographic image – image capture only	\$0
D0703 - 2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	\$0

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Covered Service	What you pay
• D0705 - Extra-oral posterior dental radiographic image – image capture only	\$0
• D0706 - Intraoral – occlusal radiographic image – image capture only	\$0
• D0707 - Intraoral – periapical radiographic image – image capture only	\$0
• D0708 - Intraoral – bitewing radiographic image – image capture only	\$0
• D0709 - Intraoral – comprehensive series of radiographic images – image capture only	\$0

Preventive Services (D1000-D1999)

- If you have not had regular dental visits (at least once every 6 months) or have been diagnosed with gum disease, you may need periodontal scaling and root planing, or full-mouth debridement before routine care such as regular cleanings can be provided.

• D1110 - Prophylaxis – adult <i>Two (D1110, D4346 or D4910) every calendar year</i>	\$0
• D1206 - Topical application of fluoride varnish <i>Two fluoride applications (D1206 or D1208) every calendar year</i>	\$0
• D1208 - Topical application of fluoride - excluding varnish <i>Two fluoride applications (D1206 or D1208) every calendar year</i>	\$0
• D1310 - Nutritional counseling for control of dental disease <i>One every calendar year</i>	\$0
• D1330 - Oral hygiene instructions <i>One every calendar year</i>	\$0

Restorative Services (D2000-D2999)

†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.

Covered Service	What you pay
- A filling is a benefit for the removal of decay, for minor repairs of tooth structure, or to replace a lost filling. - A filling includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures. - Replacement of a filling requires the existing restoration to be 2+ years old. - Fillings are limited to no more than two procedures every calendar year (any combination of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393 or D2394). - The fee for removal of an indirect restoration is included in the fee for any subsequent restorative procedure. - A crown is a benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional and cannot be repaired. - Replacement of crowns and onlays requires the existing restoration to be 5+ years old. - Crowns/onlays are limited to no more than two procedures every calendar year (any combination of D2542 - D2544, D2642 - D2644, D2710 - D2794). - Base or noble metal is covered. If an onlay or indirectly fabricated post and core is made of high noble metal, an additional fee up to \$100 per tooth will be charged for the upgrade. - Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The dentist may charge an additional fee not to exceed \$150 in addition to the listed copayment. Refer to Section 3.1, "Dental limitations and exclusions," for additional information. - One core buildup (D2950) or post and core (D2952, D2954) per tooth every 5 years. These services include the fees for resin or amalgam restorations performed on the same date of service. - One pin retention procedure (D2951) per tooth every 2 calendar years when billed with resin or amalgam restoration. D2951 is included with D2950, D2952, D2954 if billed separately.	
D2140 - Amalgam - one surface, primary or permanent	\$53
D2150 - Amalgam - two surfaces, primary or permanent	\$68

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Covered Service	What you pay
• D2160 - Amalgam - three surfaces, primary or permanent	\$82
• D2161 - Amalgam - four or more surfaces, primary or permanent	\$94
• D2330 - Resin-based composite - one surface, anterior	\$50
• D2331 - Resin-based composite - two surfaces, anterior	\$60
• D2332 - Resin-based composite - three surfaces, anterior	\$71
• D2335 - Resin-based composite - four or more surfaces or involving incisal angle (anterior)	\$85
• D2390 - Resin-based composite crown, anterior	\$114
• D2391 - Resin-based composite - one surface, posterior	\$54
• D2392 - Resin-based composite - two surfaces, posterior	\$70
• D2393 - Resin-based composite - three surfaces, posterior	\$85
• D2394 - Resin-based composite - four or more surfaces, posterior	\$96
• D2542 - Onlay - metallic - two surfaces	\$313

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Covered Service	What you pay
• D2543 - Onlay - metallic - three surfaces	\$334
• D2544 - Onlay - metallic - four or more surfaces	\$355
• D2642 - Onlay - porcelain/ceramic - two surfaces	\$293
• D2643 - Onlay - porcelain/ceramic - three surfaces	\$320
• D2644 - Onlay - porcelain/ceramic - four or more surfaces	\$352
• D2710 - Crown - resin-based composite (indirect)	\$163
• D2712 - Crown - 3/4 resin-based composite (indirect)	\$161
• D2720 - Crown - resin with high noble metal	\$346
• D2721 - Crown - resin with predominantly base metal	\$327
• D2722 - Crown - resin with noble metal	\$378
• D2740 - Crown - porcelain/ceramic	\$433
• D2750 - Crown - porcelain fused to high noble metal	\$422

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Covered Service	What you pay
• D2751 - Crown - porcelain fused to predominantly base metal	\$372
• D2752 - Crown - porcelain fused to noble metal	\$381
• D2753 - Crown - porcelain fused to titanium and titanium alloys	\$402
• D2780 - Crown - 3/4 cast high noble metal	\$441
• D2781 - Crown - 3/4 cast predominantly base metal	\$371
• D2782 - Crown - 3/4 cast noble metal	\$362
• D2783 - Crown - 3/4 porcelain/ceramic	\$464
• D2790 - Crown - full cast high noble metal	\$428
• D2791 - Crown - full cast predominantly base metal	\$368
• D2792 - Crown - full cast noble metal	\$385
• D2794 - Crown - titanium and titanium alloys	\$431
• D2915 - Re-cement or re-bond indirectly fabricated or prefabricated post and core	\$31

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

Covered Service	What you pay
<i>One recement (D2915 or D2920) per tooth every 2 calendar years</i>	
D2920 - Re-cement or re-bond crown <i>One recement (D2915 or D2920) per tooth every 2 calendar years</i>	\$32
D2928 - Prefabricated porcelain/ceramic crown – permanent tooth <i>One per tooth every 2 calendar years</i>	\$96
D2940 - Protective restoration <i>One per tooth per lifetime</i>	\$32
D2950 - Core buildup, including any pins when required <i>One (D2950, D2952 or D2954) per tooth every 5 calendar years</i>	\$76
D2951 - Pin retention - per tooth, in addition to restoration <i>One per tooth every 2 calendar years</i>	\$18
D2952 - Post and core in addition to crown, indirectly fabricated <i>One (D2950, D2952 or D2954) per tooth every 5 calendar years</i>	\$108
D2953 - Each additional indirectly fabricated post - same tooth <i>One per tooth every 5 calendar year when billed with D2952.</i>	\$56
D2954 - Prefabricated post and core in addition to crown <i>One (D2950, D2952 or D2954) per tooth every 5 calendar years</i>	\$96
D2956 - Removal of an indirect restoration on a natural tooth	\$0

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Covered Service	What you pay
D2957 - Each additional prefabricated post - same tooth <i>One once per tooth every 5 calendar years</i>	\$55
D2976 - Band stabilization – per tooth <i>One per tooth per lifetime. Benefit on posterior teeth only.</i>	\$49
D2980 - Crown repair necessitated by restorative material failure <i>One per tooth every 2 calendar years</i>	\$74
D2982 - Onlay repair necessitated by restorative material failure <i>One per tooth every 2 calendar years</i>	\$108
D2989 - Excavation of a tooth resulting in the determination of non-restorability	\$0

Endodontic Services (D3000-D3999)

- Root canals and retreatments are limited to no more than two every calendar year (any combination of D3310, D3320, D3330, D3346, D3347 or D3348)
- Placement of interim direct restoration is included in the fee for all covered endodontic procedures (D3220-D3950) when done on the same date by the same dentist/dental office.
- Retreatment of root canal therapy when performed by the same dentist/dental office within 2 calendar years is included in the fee for the original treatment; however, when performed by a different dentist it is not covered.
- A direct or indirect pulp cap is a benefit only on a vital permanent tooth with an open apex or a vital primary tooth.
- With the exception of pulp caps and pulpotomies, endodontic procedures (e.g., root canal therapy, apicoectomy, retrofill, etc.) are only a benefit on a permanent tooth with pathology.
- A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the dentist is not performing root canal therapy.

†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.

Covered Service	What you pay
D3110 - Pulp cap - direct (excluding final restoration)	\$22
D3120 - Pulp cap - indirect (excluding final restoration)	\$23
D3220 - Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament <i>One (D3220 or D3321) per tooth per lifetime</i>	\$54
D3221 - Pulpal debridement, primary and permanent teeth <i>One (D3220 or D3321) per tooth per lifetime</i>	\$80
D3310 - Endodontic therapy, anterior tooth (excluding final restoration) <i>One root canal (D3310, D3320 or D3330) per tooth per lifetime</i>	\$315
D3320 - Endodontic therapy, premolar tooth (excluding final restoration) <i>One root canal (D3310, D3320 or D3330) per tooth per lifetime</i>	\$360
D3330 - Endodontic therapy, molar tooth (excluding final restoration) <i>One root canal (D3310, D3320 or D3330) per tooth per lifetime</i>	\$488
D3331 - Treatment of root canal obstruction; non-surgical access	\$162
D3346 - Retreatment of previous root canal therapy – anterior <i>One retreatment (D3346, D3347 or D3348) per tooth every 2 calendar years</i>	\$453

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

Covered Service	What you pay
D3347 - Retreatment of previous root canal therapy – premolar <i>One retreatment (D3346, D3347 or D3348) per tooth every 2 calendar years</i>	\$507
D3348 - Retreatment of previous root canal therapy – molar <i>One retreatment (D3346, D3347 or D3348) per tooth every 2 calendar years</i>	\$625
D3410 - Apicoectomy – anterior <i>One per tooth per lifetime</i>	\$414
D3421 - Apicoectomy – premolar (first root) <i>One per tooth per lifetime</i>	\$455
D3425 - Apicoectomy – molar (first root) <i>One per tooth per lifetime</i>	\$497
D3426 - Apicoectomy – (each additional root) <i>One per tooth per lifetime</i>	\$133
D3430 – Retrograde filling – per root <i>One per tooth per lifetime</i>	\$110
D3450 – Root amputation – per root <i>One per tooth per lifetime</i>	\$271

Periodontic Services (D4000-D4999)

- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.
- If you have not had regular dental visits (at least once every 6 months) or have been diagnosed with gum disease, you may need periodontal scaling and root planing, or full-mouth debridement before routine care such as regular cleanings can be provided.

†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.

Covered Service	What you pay
D4210 - Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant <i>One (D4210 or D4211) per quadrant every 3 calendar years</i>	\$227
D4211 - Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant <i>One (D4210 or D4211) per quadrant every 3 calendar years</i>	\$107
D4212 - Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	\$0
D4240 - Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant <i>One (D4240 or D4241) per quadrant every 3 calendar years</i>	\$272
D4241 - Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant <i>One (D4240 or D4241) per quadrant every 3 calendar years</i>	\$269
D4249 - Clinical crown lengthening - hard tissue <i>One per permanent tooth per lifetime</i>	\$301
D4260 - Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant <i>One (D4260 or D4261) per quadrant every 3 calendar years</i>	\$643

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

Covered Service	What you pay
D4261 - Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant <i>One (D4260 or D4261) per quadrant every 3 calendar years</i>	\$472
D4266 - Guided tissue regeneration, natural teeth - resorbable barrier, per site <i>One (D4266 or D4267) per tooth every 3 calendar years</i>	\$267
D4267 - Guided tissue regeneration, natural teeth - non-resorbable barrier, per site <i>One (D4266 or D4267) per tooth every 3 calendar years</i>	\$256
D4341 - Periodontal scaling and root planing - four or more teeth per quadrant <i>One (D4341 or D4342) per quadrant every 2 calendar years</i>	\$0
D4342 - Periodontal scaling and root planing - one to three teeth per quadrant <i>One (D4341 or D4342) per quadrant every 2 calendar years</i>	\$0
D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation <i>Two (D1110, D4346 or D4910) every calendar year</i>	\$0
D4355 - Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit <i>One every 2 calendar years</i>	\$43

†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.

Covered Service	What you pay
D4381 - Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth <i>One per tooth every 2 calendar years</i>	\$21
D4910 - Periodontal maintenance <i>Two (D1110, D4346 or D4910) every calendar year</i>	\$0
D4921 - Gingival irrigation with a medicinal agent – per quadrant	\$0
Prosthodontic, removable (D5000-D5999)	
- For all listed dentures and partial dentures, the copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, the copayment includes after delivery adjustments and tissue conditioning, if needed, for the first three months after placement. You must continue to be eligible, and the service must be provided at the same dentist's facility where the denture was originally delivered. - Replacement of a denture, partial denture or overdenture requires the existing denture to be 5+ years old. - The replacement of a removable partial denture with a full denture is covered, within the 5-year frequency limitation period, when natural teeth are lost. - Interim partial dentures (stayplates) are limited to the replacement of extracted anterior teeth for adults during a healing period.	
D5110 - Complete denture - maxillary <i>One maxillary denture (D5110, D5130 or D5863) every 5 calendar years</i>	\$447
D5120 - Complete denture – mandibular <i>One mandibular denture (D5120, D5140 or D5865) every 5 calendar years</i>	\$471
D5130 - Immediate denture – maxillary <i>One maxillary denture (D5110, D5130 or D5863) every 5 calendar years</i>	\$435

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Covered Service	What you pay
D5140 - Immediate denture – mandibular <i>One mandibular denture (D5120, D5140 or D5865) every 5 calendar years</i>	\$417
D5211 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) <i>One partial maxillary denture (D5211, D5213, D5221, D5223, D5225, D5227 or D5864) every 5 calendar years</i>	\$309
D5212 - Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) <i>One partial mandibular denture (D5212, D5214, D5222, D5224, D5226, D5228 or D5866) every 5 calendar years</i>	\$326
D5213 - Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) <i>One partial maxillary denture (D5211, D5213, D5221, D5223, D5225, D5227 or D5864) every 5 calendar years</i>	\$474
D5214 - Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) <i>One partial mandibular denture (D5212, D5214, D5222, D5224, D5226, D5228 or D5866) every 5 calendar years</i>	\$467
D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) <i>One partial maxillary denture (D5211, D5213, D5221, D5223, D5225, D5227 or D5864) every 5 calendar years</i>	\$294

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

Covered Service	What you pay
D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) <i>One partial mandibular denture (D5212, D5214, D5222, D5224, D5226, D5228 or D5866) every 5 calendar years</i>	\$287
D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) <i>One partial maxillary denture (D5211, D5213, D5221, D5223, D5225, D5227 or D5864) every 5 calendar years</i>	\$424
D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) <i>One partial mandibular denture (D5212, D5214, D5222, D5224, D5226, D5228 or D5866) every 5 calendar years</i>	\$428
D5225 - Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) <i>One partial maxillary denture (D5211, D5213, D5221, D5223, D5225, D5227 or D5864) every 5 calendar years</i>	\$398
D5226 - Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) <i>One partial mandibular denture (D5212, D5214, D5222, D5224, D5226, D5228 or D5866) every 5 calendar years</i>	\$400

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Covered Service	What you pay
D5227 - Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth) <i>One partial maxillary denture (D5211, D5213, D5221, D5223, D5225, D5227 or D5864) every 5 calendar years</i>	\$395
D5228 - Immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth) <i>One partial mandibular denture (D5212, D5214, D5222, D5224, D5226, D5228 or D5866) every 5 calendar years</i>	\$366
D5410 - Adjust complete denture – maxillary <i>Two every calendar year</i>	\$25
D5411- Adjust complete denture – mandibular <i>Two every calendar year</i>	\$25
D5421 - Adjust partial denture – maxillary <i>Two every calendar year</i>	\$27
D5422 - Adjust partial denture – mandibular <i>Two every calendar year</i>	\$26
D5511 - Repair broken complete denture base, mandibular <i>One every calendar year</i>	\$57
D5512 - Repair broken complete denture base, maxillary <i>One every calendar year</i>	\$56
D5520 – Replace missing or broken teeth - complete denture (each tooth) <i>One every calendar year</i>	\$47

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

Covered Service	What you pay
D5611 - Repair resin partial denture base, mandibular <i>One (D5611 or D5621) every calendar year</i>	\$55
D5612 - Repair resin partial denture base, maxillary <i>One (D5612 or D5622) every calendar year</i>	\$55
D5621 - Repair cast partial framework, mandibular <i>One (D5611 or D5621) every calendar year</i>	\$69
D5622 - Repair cast partial framework, maxillary <i>One (D5612 or D5622) every calendar year</i>	\$65
D5630 - Repair or replace broken retentive/clasping materials – per tooth <i>One (D5610 - D5660) every calendar year</i>	\$64
D5640 - Replace broken teeth - per tooth <i>One (D5610 - D5660) every calendar year</i>	\$52
D5650 - Add tooth to existing partial denture <i>One (D5610 - D5660) every calendar year</i>	\$59
D5660 - Add clasp to existing partial denture - per tooth <i>One (D5610 - D5660) every calendar year</i>	\$65
D5710 - Rebase complete maxillary denture <i>One every 2 calendar years</i>	\$145
D5711 - Rebase complete mandibular denture <i>One every 2 calendar years</i>	\$141
D5720 - Rebase maxillary partial denture <i>One every 2 calendar years</i>	\$138

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

Covered Service	What you pay
D5721 - Rebase mandibular partial denture <i>One every 2 calendar years</i>	\$143
D5730 - Reline complete maxillary denture (direct) <i>Two (D5730, D5740, D5750, D5760 or D5765) per calendar year</i>	\$92
D5731 - Reline complete mandibular denture (direct) <i>Two (D5731, D5741, D5751, D5761 or D5765) per calendar year</i>	\$89
D5740 - Reline maxillary partial denture (direct) <i>Two (D5730, D5740, D5750, D5760 or D5765) per calendar year</i>	\$84
D5741 - Reline mandibular partial denture (direct) <i>Two (D5731, D5741, D5751, D5761 or D5765) per calendar year</i>	\$85
D5750 - Reline complete maxillary denture (indirect) <i>Two (D5730, D5740, D5750, D5760 or D5765) per calendar year</i>	\$122
D5751- Reline complete mandibular denture (indirect) <i>Two (D5731, D5741, D5751, D5761 or D5765) per calendar year</i>	\$122
D5760 - Reline maxillary partial denture (indirect) <i>Two (D5730, D5740, D5750, D5760 or D5765) per calendar year</i>	\$120
D5761- Reline mandibular partial denture (indirect) <i>Two (D5731, D5741, D5751, D5761 or D5765) per calendar year</i>	\$121

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

Covered Service	What you pay
D5765 - Soft liner for complete or partial removable denture – indirect <i>Two (D5730, D5740, D5750, D5760, D5765, D5731, D5741, D5751 or D5761) per calendar year</i>	\$112
D5820 - Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary <i>One every 5 calendar years</i>	\$179
D5821 - Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular <i>One every 5 calendar years</i>	\$179
D5850 - Tissue conditioning, maxillary <i>One every calendar year</i>	\$47
D5851 - Tissue conditioning, mandibular <i>One every calendar year</i>	\$49
D5863 - Overdenture – complete maxillary <i>One maxillary denture (D5110, D5130 or D5863) every 5 calendar years</i>	\$668
D5864 - Overdenture – partial maxillary <i>One partial maxillary denture (D5211, D5213, D5221, D5223, D5225, D5227 or D5864) every 5 calendar years</i>	\$522
D5865 - Overdenture – complete mandibular <i>One mandibular denture (D5120, D5140 or D5865) every 5 calendar years</i>	\$738
D5866 - Overdenture – partial mandibular <i>One partial mandibular denture (D5212, D5214, D5222, D5224, D5226, D5228 or D5866) every 5 calendar years</i>	\$518

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

Covered Service	What you pay
Prosthodontics, fixed (D6200-D6999)	
- When a crown and/or pontic exceeds six units in the same treatment plan, you may be charged an additional \$175 per unit, beyond the 6th unit. - Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old. - Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The dentist may charge an additional fee not to exceed \$150 in addition to the listed copayment below. Refer to Section 3.1, "Dental limitations and exclusions," for additional information.	
• D6210 - Pontic - cast high noble metal	\$303
• D6211 - Pontic - cast predominantly base metal	\$245
• D6212 - Pontic - cast noble metal	\$283
• D6240 - Pontic - porcelain fused to high noble metal	\$344
• D6241 - Pontic - porcelain fused to predominantly base metal	\$269
• D6242 - Pontic - porcelain fused to noble metal	\$293
• D6243 - Pontic - porcelain fused to titanium and titanium alloys	\$286
• D6245 - Pontic - porcelain/ceramic	\$337

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

Covered Service	What you pay
• D6250 - Pontic - resin with high noble metal	\$282
• D6251 - Pontic - resin with predominantly base metal	\$255
• D6252 - Pontic - resin with noble metal	\$245
• D6602 - Retainer inlay - cast high noble metal, two surfaces	\$146
• D6603 - Retainer inlay - cast high noble metal, three or more surfaces	\$285
• D6604 - Retainer inlay - cast predominantly base metal, two surfaces	\$138
• D6605 - Retainer inlay - cast predominantly base metal, three or more surfaces	\$237
• D6606 - Retainer inlay - cast noble metal, two surfaces	\$177
• D6607 - Retainer inlay - cast noble metal, three or more surfaces	\$380
• D6608 - Retainer onlay - porcelain/ceramic, two surfaces	\$268
• D6609 - Retainer onlay - porcelain/ceramic, three or more surfaces	\$315
• D6610 - Retainer onlay - cast high noble metal, two surfaces	\$276

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

Covered Service	What you pay
D6611 - Retainer onlay - cast high noble metal, three or more surfaces	\$279
D6612 - Retainer onlay - cast predominantly base metal, two surfaces	\$272
D6613 - Retainer onlay - cast predominantly base metal, three or more surfaces	\$281
D6614 - Retainer onlay - cast noble metal, two surfaces	\$259
D6615 - Retainer onlay - cast noble metal, three or more surfaces	\$284
D6720 - Retainer crown - resin with high noble metal	\$426
D6721 - Retainer crown - resin with predominantly base metal	\$369
D6722 - Retainer crown - resin with noble metal	\$438
D6740 - Retainer crown - porcelain/ceramic	\$442
D6750 - Retainer crown - porcelain fused to high noble metal	\$427
D6751 - Retainer crown - porcelain fused to predominantly base metal	\$384
D6752 - Retainer crown - porcelain fused to noble metal	\$393

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

Covered Service	What you pay
D6753 - Retainer crown - porcelain fused to titanium and titanium alloys	\$430
D6780 - Retainer crown - 3/4 cast high noble metal	\$444
D6781 - Retainer crown - 3/4 cast predominantly base metal	\$369
D6782 - Retainer crown - 3/4 cast noble metal	\$448
D6783 - Retainer crown - 3/4 porcelain/ceramic	\$438
D6784 - Retainer crown 3/4 - titanium and titanium alloys	\$528
D6790 - Retainer crown - full cast high noble metal	\$431
D6791 - Retainer crown - full cast predominantly base metal	\$372
D6792 - Retainer crown - full cast noble metal	\$394
D6930 - Re-cement or re-bond fixed partial denture <i>One every 2 calendar years</i>	\$44
D6940 - Stress breaker <i>One every 5 calendar years</i>	\$80
D6980 - Fixed partial denture repair necessitated by restorative material failure <i>One every 2 calendar years</i>	\$86

Oral and Maxillofacial Surgery (D7000-D7999)

- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.

†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.

Covered Service	What you pay
- Extractions are limited to three every calendar year (any combination of D7140, D7210, D7220, D7230, D7240, D7241, D7250 or D7251). - Nerve dissection is included in the fee for the removal of an impacted tooth, complete bony, with unusual surgical complications, as part of that extraction procedure. Otherwise, nerve dissection is not covered.	
D7140 - Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$53
D7210 - Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$113
D7220 - Removal of impacted tooth - soft tissue	\$138
D7230 - Removal of impacted tooth - partially bony	\$182
D7240 - Removal of impacted tooth - completely bony	\$215
D7241 - Removal of impacted tooth - completely bony, with unusual surgical complications.	\$246
D7250 - Removal of residual tooth roots (cutting procedure)	\$124
D7251 - Coronectomy - intentional partial tooth removal, impacted teeth only	\$242
D7259 - Nerve dissection	\$0
D7270 - Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth <i>One per tooth per lifetime</i>	\$144

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

Covered Service	What you pay
D7280 - Exposure of an unerupted tooth <i>One per tooth per lifetime</i>	\$246
D7282 - Mobilization of erupted or malpositioned tooth to aid eruption <i>One per tooth per lifetime</i>	\$149
D7284 - Excisional biopsy of minor salivary glands <i>One in same day</i>	\$189
D7286 - Incisional biopsy of oral tissue – soft <i>One per day</i>	\$173
D7288 - Brush biopsy - transepithelial sample collection <i>One every calendar year</i>	\$59
D7310 - Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant <i>One (D7310 or D7311) per quadrant per lifetime</i>	\$104
D7311 - Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant <i>One (D7310 or D7311) per quadrant per lifetime</i>	\$96
D7320 - Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant <i>One (D7320 or D7321) per quadrant per lifetime</i>	\$167
D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant <i>One (D7320 or D7321) per quadrant per lifetime</i>	\$124

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

Covered Service	What you pay
D7340 - Vestibuloplasty - ridge extension (secondary epithelialization) <i>One per arch per lifetime</i>	\$280
D7350 - Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) <i>One per arch per lifetime</i>	\$461
D7450 - Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm <i>One per day</i>	\$299
D7451 - Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm <i>One per day</i>	\$490
D7471 - Removal of lateral exostosis (maxilla or mandible) <i>One per quadrant per lifetime</i>	\$350
D7472 - Removal of torus palatinus <i>One per arch per lifetime</i>	\$435
D7473 - Removal of torus mandibularis <i>One per quadrant per lifetime</i>	\$366
D7510 - Incision and drainage of abscess - intraoral soft tissue <i>One per day</i>	\$86
D7922 - Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	\$0
D7953 - Bone replacement graft for ridge preservation - per site <i>One in a lifetime per site</i>	\$234

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Covered Service	What you pay
D7970 - Excision of hyperplastic tissue - per arch <i>One per arch per lifetime</i>	\$245
D7971 - Excision of pericoronal gingiva <i>One per tooth per lifetime</i>	\$107
Adjunctive General Services (D9000-D9999)	
- A maximum of 60 minutes of either general anesthesia or intravenous moderate sedation is allowed per date of service. Additional units are not covered. - General anesthesia and intravenous moderate (conscious) sedation is a benefit only when provided by a dentist in conjunction with covered oral surgery procedures or selected endodontic and periodontal surgical procedures. Benefits are limited to one type of anesthesia per day.	
D9110 - Palliative treatment of dental pain – per visit <i>One per day</i>	\$0
D9211 - Regional block anesthesia	\$0
D9212 - Trigeminal division block anesthesia	\$0
D9215 - Local anesthesia in conjunction with operative or surgical procedures	\$0
D9219 - Evaluation for moderate sedation, deep sedation or general anesthesia	\$0
D9222 - Deep sedation/general anesthesia – first 15 minutes	\$101
D9223 - Deep sedation/general anesthesia – each subsequent 15 minute increment	\$96
D9224 - Administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof	\$101

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Covered Service	What you pay
D9225 - Administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof	\$96
D9230 - Inhalation of nitrous oxide/analgesia, anxiolysis <i>Three every calendar year</i>	\$22
D9239 - Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	\$90
D9243 - Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	\$80
D9244 - In-office administration of minimal sedation – single drug – enteral <i>Three (D9244, D9245, D9246 or D9247) every calendar year</i>	\$72
D9245 - In-office administration of minimal sedation – single drug – enteral <i>Three (D9244, D9245, D9246 or D9247) every calendar year</i>	\$72
D9246 - Administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof <i>Three (D9244, D9245, D9246 or D9247) every calendar year</i>	\$50
D9247 - Administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof <i>Three (D9244, D9245, D9246 or D9247) every calendar year</i>	\$22
D9310 - Consultation - diagnostic service provided by dentist or physician other than requesting	\$67

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Covered Service	What you pay
dentist or physician <i>One per lifetime per provider</i>	
• D9311 - Consultation with a medical health care professional	\$0
• D9430 - Office visit for observation (during regularly scheduled hours) - no other services performed	\$23
• D9440 - Office visit - after regularly scheduled hours <i>One every calendar year</i>	\$54
• D9450 - Case presentation, subsequent to detailed and extensive treatment planning	\$0
• D9910 - Application of desensitizing medicament	\$0
• D9912 - Pre-visit patient screening	\$0
• D9930 - Treatment of complications (post-surgical) - unusual circumstances, by report	\$0
• D9932 - Cleaning and inspection of removable complete denture, maxillary	\$0
• D9933 - Cleaning and inspection of removable complete denture, mandibular	\$0
• D9934 - Cleaning and inspection of removable partial denture, maxillary	\$0
• D9935 - Cleaning and inspection of removable partial denture, mandibular	\$0
• D9951 - Occlusal adjustment – limited <i>One every 5 calendar years</i>	\$46

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Covered Service	What you pay
D9952 - Occlusal adjustment – complete <i>One every 5 calendar years</i>	\$151
D9975 - External bleaching for home application, per arch; includes materials and fabrication of custom trays <i>limited to one bleaching tray and gel for two weeks of self-treatment</i>	\$56
D9990 - Certified translation or sign-language services – per visit	\$0
D9991 - Dental case management - addressing appointment compliance barriers	\$0
D9992 - Dental case management - care coordination	\$0
D9995 - Teledentistry – synchronous; real-time encounter	\$0
D9996 - Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	\$0
D9997 - Dental case management - patients with special health care needs	\$0
If you need emergency dental care, you should contact your assigned DeltaCare USA dentist or Delta Dental Customer Service at 1-844-519-8693, Monday through Friday, 8 a.m. to 8 p.m.; October 1 – March 31, 8 a.m. to 8 p.m. 7 days a week, (TTY users should call 711). If you receive covered emergency dental care received from your assigned DeltaCare USA dentist, you pay the same cost-sharing as nonemergency dental care.	

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Covered Service	What you pay
Covered emergency dental care received from a dentist other than your assigned DeltaCare USA dentist is limited to \$100 per emergency, less your cost-sharing. Also, covered emergency care is limited to necessary care required to stabilize your condition and provide palliative relief. See Section 3.1, “Dental limitations and exclusions,” for more information. Note: Additional dental benefits are covered if you are enrolled in optional supplemental benefits (Advantage Plus) described in Section 2.1 of this chapter.	
 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:	\$0

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

Covered Service	What you pay
- Supplies to monitor your blood glucose: blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors  Diabetes self-management training under certain conditions	
Diabetic monitors (blood glucose and continuous glucose)	\$0
For people with diabetes who have severe diabetic foot disease, one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes) including fitting	20% coinsurance
Durable medical equipment (DME) and related supplies† (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.	\$0 for canes and crutches provided at a network medical office, home phototherapy for psoriasis treatment, and phototherapy equipment for atopic dermatitis. 20% coinsurance for all other covered DME items. Oxygen equipment Your cost-sharing for Medicare oxygen equipment coverage is 20% coinsurance, every time you receive equipment.

†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.

Covered Service	What you pay
We also cover the following DME not covered by Medicare when medically necessary: • Phototherapy equipment for atopic dermatitis treatment. • Bed accessories such as board, table, or support device, bilirubin light, surgical boot/shoe, and heel or elbow protector.	Your cost-sharing won't change after you're enrolled for 36 months.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost-sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. You have worldwide emergency care coverage.	You pay the following per Emergency Department visit, depending upon the plan in which you are enrolled: • \$115 for Basic 1 plan members. • \$130 for Enhanced 1 plan members. This copayment does not apply if you are immediately admitted directly to the hospital as an inpatient (it does apply if you are admitted to the hospital as an outpatient; for example, if you are admitted for observation). †If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost-sharing you would pay at a network hospital.

†Your provider must obtain prior authorization from our plan.

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

Covered Service	What you pay
Fitness benefit (One Pass®)* A fitness benefit is provided through the One Pass program to help members take control of their health and feel their best. The One Pass program includes: • Gyms and Fitness Locations: You receive a membership with access to a wide variety of in-network gyms through the core network. Fitness locations include national, local, and community fitness centers and boutique studios. You can use any in-network location, and you may use multiple participating fitness locations during the same month. • 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 http://www.YourOnePass.com or call 1-877-614-0618 (TTY 711), Monday through Friday, 9 a.m. to 10 p.m. The following are not covered: Additional services (such as personal training, fee-based group fitness classes, expanded access hours, or additional classes outside of the standard membership offering).	\$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.

Covered Service	What you pay
One Pass® is a registered trademark of One Pass Solutions, Inc. in the U.S. and other jurisdictions and is a voluntary program. The One Pass program and amenities vary by plan, area, and location. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. One Pass is not responsible for the services or information provided by third parties. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them.	
 Health and wellness education programs These are programs focused on health conditions such as high blood pressure, cholesterol, diabetes, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness, and stress management. For more information about our healthy living programs, please call our Member Services Department, or go to our website at kp.org.	\$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.	You pay the following per visit, depending upon the plan in which you are enrolled: • \$35 for Basic 1 plan members. • \$25 for Enhanced 1 plan members.
• Routine hearing exam (one per calendar year). Note: Hearing aids are not covered unless you are enrolled in Advantage Plus as described in Section 2.1 of this chapter.	\$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.

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.
Home infusion therapy†	\$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

†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.

Covered Service	What you pay
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	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.
Home medical care not covered by Medicare (Advanced Care at Home)† We cover medical care in your home that is not otherwise covered by Medicare in certain situations to provide you with an alternative to receiving or	\$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.

Covered Service	What you pay
continuing to receive acute care in a hospital. Services in the home must be: • Prescribed by a network hospitalist who has determined that based on your health status, treatment plan, and home setting that you can be treated safely and effectively in the home. • Elected by you because you prefer to receive the care described in your treatment plan in your home. Medically Home is our network provider and will provide the following services and items in your home in accord with your treatment plan for as long as they are prescribed by a network hospitalist: • Home visits by RNs, physical therapists, occupational therapists, speech therapists, respiratory therapists, nutritionist, home health aides, and other healthcare professionals in accord with the home care treatment plan and the provider's scope of practice and license. • Communication devices to allow you to contact Medically Home's command center 24 hours a day, 7 days a week. This includes needed communication technology to support reliable communication, and a PERS alert device to contact Medically Home's command center if you are unable to get to a phone. • Equipment necessary to ensure that you are monitored appropriately in your home: blood pressure cuff/monitor, pulse oximeter, scale, and thermometer. • Mobile imaging and tests such as X-rays, labs, and EKGs. • The following safety items: shower stools, raised toilet seats, grabbers, long handle shoehorn, and sock aid.	

†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.

Covered Service	What you pay
Meals while you are receiving acute care in the home.	
In addition, for Medicare-covered services and items listed below, the cost-sharing indicated elsewhere in this Medical Benefits Chart does not apply when the services and items are prescribed as part of your home treatment plan: - Durable medical equipment. - Medical supplies. - Ambulance transportation to and from network facilities when ambulance transport is medically necessary. - The following services at a network facility if the services are part of your home treatment plan: - Network Emergency Department visits associated with this benefit. - Radiology services associated with this benefit. The cost-sharing indicated elsewhere in this Medical Benefits Chart will apply to all other services and items that aren't part of your home treatment plan (for example, DME unrelated to your home treatment plan) or are part of your home treatment plan, but are not provided in your home except as listed above. Note: For prescription drug cost-sharing information, please refer to the Medicare Part B prescription drug section in this chart and Chapter 6 for Medicare Part D prescription drugs.	\$0
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your

†Your provider must obtain prior authorization from our plan.

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

Covered Service	What you pay
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 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,	terminal prognosis are paid for by Original Medicare, not our plan.

†Your provider must obtain prior authorization from our plan.

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

Covered Service	What you pay
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 your plan cost-sharing amount for these services. For drugs that may be covered by our plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition, you pay cost-sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost-sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4. Note: If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.	
Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	You pay the following per visit, depending upon the plan in which you are enrolled and the type of visit: • \$0 per primary care visit and \$35 per specialty care visit for Basic 1 plan members. • \$0 per primary care visit and \$25 per specialty care visit for Enhanced 1 plan members.

†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.

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've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you at high or intermediate risk of getting Hepatitis B • 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) • Meals including special diets	Cost-sharing is charged for each inpatient stay. You pay the following depending upon the plan in which you are enrolled: • \$407 per day for days 1–6 of a hospital stay for Basic 1 plan members. • \$350 per day for days 1–6 of a hospital stay for Enhanced 1 plan members. Thereafter you pay \$0 for the remainder of your covered

†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.

Covered Service	What you pay
• Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If we provide transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion in accord with our travel and lodging guidelines, which are available from Member Services. • Blood - including storage and administration.	hospital stay. Also, you do not pay the copayment listed above for the day you are discharged unless you are admitted and discharged on the same day. †If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you'd pay at a network hospital. Note: If you are admitted to the hospital in 2026 and are not discharged until sometime in 2027, the 2026 cost-sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility.

†Your provider must obtain prior authorization from our plan.

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

Covered Service	What you pay
- 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 from the Medicare fact sheet <i>Medicare Hospital Benefits</i> available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	
Inpatient services in a psychiatric hospital† Covered services include mental health care services that require a hospital stay. - We cover up to 190 days per lifetime for inpatient stays in a Medicare-certified psychiatric hospital. The number of covered lifetime hospitalization days is reduced by the number of inpatient days for mental health treatment previously covered by Medicare in a psychiatric hospital. - The 190 day limit doesn't apply to mental health stays in a psychiatric unit of a general hospital.	Cost-sharing is charged for each inpatient stay. You pay the following depending upon the plan in which you are enrolled: \$407 per day for days 1–5 of a hospital stay for Basic 1 plan members. \$350 per day for days 1–5 of a hospital stay for Enhanced 1 plan members. 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. Note: If you are admitted to the hospital in 2026 and are not

†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.

Covered Service	What you pay
	discharged until sometime in 2027, the 2026 cost-sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility.
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay† If you've used up your inpatient mental health or skilled nursing facility (SNF) benefits or if the inpatient 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 adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition	If your inpatient or SNF stay is no longer covered, we will continue to cover Medicare Part B services at the applicable cost-sharing listed elsewhere in this Medical Benefits Chart when provided by network providers.

†Your provider must obtain prior authorization from our plan.

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

Covered Service	What you pay
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 sustain weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B drugs† These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include: Drugs that usually aren't self-administered by the patient and are injected or infused while you get	0% or 20% coinsurance depending on the drug. Please call Member Services to find out which drugs are provided at the 20% coinsurance. Some drugs may be less than 20% if those drugs are

†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.

Covered Service	What you pay
physician, hospital outpatient, or ambulatory surgical center services • 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 • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • The Alzheimer's drug, Leqembi® (generic name lecanemab) is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment. • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar® • Parenteral and enteral nutrition (intravenous and tube feeding)	determined to exceed the amount of inflation.
• Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • 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	Up to a 30-day supply, you pay the following for Medicare Part B drugs on our formulary when obtained from a network pharmacy: • \$0 for generic drugs. • \$47 for brand-name drugs, except you pay \$35 for Part B insulin drugs furnished through an item of DME.

†Your provider must obtain prior authorization from our plan.

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

Covered Service	What you pay
immunosuppressive drugs if Part B doesn't cover them • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • 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 • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • 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 Note: We also cover some vaccines under Part B and most adult vaccines under our Part D drug benefit.	

†Your provider must obtain prior authorization from our plan.

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

Covered Service	What you pay
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 <i>Provider Directory</i> for appointment and advice telephone numbers.	\$0
 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	0% - 20% coinsurance for clinically administered Medicare Part B drugs depending on the

†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.

Covered Service	What you pay
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)	drug when provided by an Opioid Treatment Program. Some drugs may be less than 20% if those drugs are determined to exceed the amount of inflation.
• Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	You pay the following per visit, depending upon the plan in which you are enrolled: • \$35 for Basic 1 plan members. • \$25 for Enhanced 1 plan members.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to: • †Laboratory tests (prior authorization does not apply to routine lab services) • †Diagnostic non-laboratory tests such as electrocardiograms (EKGs), holter monitoring, and electroencephalograms (EEGs) when your doctor or other health care provider orders them to treat a medical problem (prior authorization does not apply to routine blood tests and in-office procedures)	\$0 for services performed in a medical office setting. For services performed in an outpatient hospital setting, you pay the following per encounter, depending upon the plan in which you are enrolled: • \$35 for Basic 1 plan members. • \$20 for Enhanced 1 plan members.
• †Ultrasounds.	For services performed in a medical office setting, you pay the following per visit, depending upon the plan in which you are enrolled: • \$10 for Basic 1 plan members.

†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.

Covered Service	What you pay
	• \$0 for Enhanced 1 plan members. For services performed in an outpatient hospital setting, you pay the following per encounter, depending upon the plan in which you are enrolled: • \$35 for Basic 1 plan members. • \$50 for Enhanced 1 plan members.
• X-rays.	For services performed in a medical office setting, you pay the following per encounter, depending upon the plan in which you are enrolled: • \$10 for Basic 1 plan members. • \$0 for Enhanced 1 plan members. For services performed in an outpatient hospital setting, you pay the following per encounter, depending upon the plan in which you are enrolled: • \$35 for Basic 1 plan members. • \$50 for Enhanced 1 plan members.
• Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Blood-including storage and administration	\$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.

Covered Service	What you pay
†Radiation (radium and isotope) therapy including technician materials and supplies.	You pay the following per visit, depending upon the plan in which you are enrolled: • \$35 for Basic 1 plan members. • \$25 for Enhanced 1 plan members.
†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.	For services performed in a medical office setting, you pay the following per encounter, depending upon the plan in which you are enrolled: • \$350 for Basic 1 plan members. • \$210 for Enhanced 1 plan members. You pay the following per encounter in an outpatient hospital setting depending upon the plan in which you are enrolled: • \$400 for Basic 1 plan members. • \$290 for Enhanced 1 plan members.
- Other outpatient diagnostic tests: †Any diagnostic test or special procedure that is provided in an outpatient department of a hospital or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.	You pay the following per visit, depending upon the plan in which you are enrolled: • \$375 for Basic 1 plan members. • \$300 for Enhanced 1 plan members.

†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.

Covered Service	What you pay
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 from the Medicare fact sheet <i>Medicare Hospital Benefits</i> available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	When admitted directly to the hospital for observation as an outpatient, you pay the following per stay, depending upon the plan in which you are enrolled: • \$375 for Basic 1 plan members. • \$300 for Enhanced 1 plan members. Note: There's no additional charge for outpatient observation stays when transferred for observation from an Emergency Department or following outpatient surgery.
Outpatient hospital services† We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	Emergency Department You pay the following per visit, depending upon the plan in which you are enrolled: • \$115 for Basic 1 plan members. • \$130 for Enhanced 1 plan members. †Outpatient surgery

†Your provider must obtain prior authorization from our plan.

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

Covered Service	What you pay
	You pay the following per visit, depending upon the plan in which you are enrolled: • \$375 for Basic 1 plan members. • \$300 for Enhanced 1 plan members. 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	You pay the following per encounter, depending upon the plan in which you are enrolled: • \$35 for Basic 1 plan members. • \$20 for Enhanced 1 plan members.
• Mental health care, including care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be required without it	You pay the following per day, depending upon the plan in which you are enrolled: • \$55 for Basic 1 plan members. • \$50 for Enhanced 1 plan members.
• X-rays and other radiology services billed by the hospital	X-rays You pay the following per encounter, depending upon the plan in which you are enrolled: • \$35 for Basic 1 plan members.

†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.

Covered Service	What you pay
	• \$50 for Enhanced 1 plan members. MRI, CT, and PET You pay the following per encounter, depending upon the plan in which you are enrolled: • \$400 for Basic 1 plan members. • \$290 for Enhanced 1 plan members. Radiation therapy You pay the following per visit, depending upon the plan in which you are enrolled: • \$35 for Basic 1 plan members. • \$25 for Enhanced 1 plan members.
• Medical supplies such as splints and casts	\$0
• Certain drugs and biologicals you can't give yourself	You pay 0% or 20% coinsurance depending on the drug. Please call Member Services to find out which drugs are provided at the 20% coinsurance. Some drugs may be less than 20% if those drugs are determined to exceed the amount of inflation.

Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.

†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.

Covered Service	What you pay
Outpatient mental health care† Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker (CSW), clinical nurse specialist (CNS), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. Prior authorization only applies to ECT electronic therapy and biofeedback.	You pay the following per visit, depending upon the type of visit and the plan in which you are enrolled: • For Basic 1 plan members: ○ \$35 per individual therapy visit ○ \$17 per group therapy visit • For Enhanced 1 plan members: ○ \$25 per individual therapy visit ○ \$12 per group therapy visit
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	You pay the following per visit, depending upon the plan in which you are enrolled: • \$35 for Basic 1 plan members. • \$25 for Enhanced 1 plan members.
Outpatient substance use disorder services We cover individual and group therapy sessions for chemical dependency and substance abuse.	You pay the following per visit, depending upon the type of visit and the plan in which you are enrolled: • For Basic 1 plan members: ○ \$35 per individual therapy visit ○ \$17 per group therapy visit • For Enhanced 1 plan members:

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

Covered Service	What you pay
	○ \$25 per individual therapy visit ○ \$12 per group therapy 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.	You pay the following per visit, depending upon the plan in which you are enrolled: ● \$375 for Basic 1 plan members. ● \$300 for Enhanced 1 plan members.
Over-the-Counter (OTC) items You will receive a preloaded healthy extras card with the quarterly allowance listed on the right to purchase eligible OTC items both online and at participating retail stores, including at Kaiser Permanente retail pharmacies. The list of eligible items is subject to change. Your card will be reloaded on January 1, April 1, July 1, and October 1. Any unused portion of the quarterly allowance will not roll over to the next quarter. The cost of eligible OTC items will be covered up to the balance available on your card. If there is a remaining amount to pay, you must use another form of payment. You can't use your healthy extras card for tips or any fees for service, delivery, shipping, or vehicle-loading. Fees and minimum order requirements vary by retailers. Please review details about fees on the checkout page prior to placing an online order. You will be prompted to enter another	You pay \$0 up to the \$35 quarterly allowance. ● Note: This benefit is available on the same card described under Special Supplemental Benefits for the Chronically Ill (SSBCI) 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.

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

†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.

Covered Service	What you pay
Members can download the OTC Network mobile app directly from the iTunes App Store or GooglePlay. Search “OTC Network” to download. Note: Any unused amounts are forfeited upon disenrollment from our plan.	
Partial hospitalization services and intensive outpatient services †<i>Partial hospitalization</i> 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.	You pay the following per day, depending upon the plan in which you are enrolled: • \$55 for Basic 1 plan members. • \$50 for Enhanced 1 plan members.
<i>Intensive outpatient service</i> 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.	You pay the following per day, depending upon the plan in which you are enrolled: • \$55 for Basic 1 plan members. • \$50 for Enhanced 1 plan members.

†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.

Covered Service	What you pay
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 - Injection visits, including allergy injections - Basic hearing and balance exams performed by a network provider, if your doctor orders it to see if you need medical treatment	Provider office visits You pay the following per visit, depending upon the plan in which you are enrolled and the type of visit: \$0 per primary care visit and \$35 per specialty care visit for Basic 1 plan members except you pay \$0 for house calls. \$0 per primary care visit and \$25 per specialty care visit for Enhanced 1 plan members except you pay \$0 for house calls. †Outpatient surgery You pay the following per visit, depending upon the plan in which you are enrolled: \$375 for Basic 1 plan members. \$300 for Enhanced 1 plan members.
- Consultation, diagnosis, and treatment by a specialist - Second opinion by another network provider prior to surgery - Care at our after-hours care centers. If you need nonemergency care after your PCP's office is closed, we have outpatient facilities that provide after-hours care. Please refer to the <i>Provider Directory</i> for locations and hours of operation	You pay the following per visit, depending upon the plan in which you are enrolled: \$35 per specialty care visit for Basic 1 plan members. \$25 per specialty care visit for Enhanced 1 plan members.

†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.

Covered Service	What you pay
• Certain telehealth services, including: primary and specialty care, which includes skilled nursing facility services, cardiac rehabilitation services, urgently needed services, intensive outpatient program services, home health services, mental health, physical therapy and speech-language pathology services, podiatry services, psychiatric services, opioid treatment program services, lab services, diagnostic procedures and tests, outpatient substance abuse, durable medical equipment, medical supplies, diabetic supplies, dialysis services, kidney disease education services, diabetes self-management training, Medicare Part B insulin drugs, other Medicare Part B drugs, hearing exams, preparation for surgery or a hospital stay, and follow up visits after a hospital stay, surgery, or Emergency Department visit. Services will only be provided by telehealth when deemed clinically appropriate by the network provider rendering the service ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. We offer the following means of telehealth: ○ Interactive video visits for professional services when care can be provided in this format as determined by a network provider ○ Scheduled telephone appointment visits for professional services when care can be provided in this format as determined by a network provider • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based	\$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.

Covered Service	What you pay
renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: ○ You're not a new patient and ○ The check-in isn't related to an office visit in the past 7 days and ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: ○ You're not a new patient and ○ The evaluation isn't related to an office visit in the past 7 days and ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record	
Podiatry services Covered services include:	Office visits

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

Covered Service	What you pay
• 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	You pay the following per specialty care visit, depending upon the plan in which you are enrolled: • \$35 for Basic 1 plan members. • \$25 for Enhanced 1 plan members. †Outpatient surgery You pay the following per visit depending upon the plan in which you are enrolled: • \$375 for Basic 1 plan members. • \$300 for Enhanced 1 plan members.
 Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication including the fee for injecting the drug, if applicable • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months • Up to 8 HIV screenings every 12 months • A one-time hepatitis B virus screening	There is no coinsurance, copayment, or deductible for the PrEP benefit.
 Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months:	There is no coinsurance, copayment, or deductible for an

†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.

Covered Service	What you pay
- Digital rectal exam - Prostate Specific Antigen (PSA) test	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. We also cover the following items and supplies not covered by Medicare when medically necessary: Skin sealants and protectants.	\$0 for surgically implanted internal devices, slings and splints when received in a network medical office, and skin sealants and protectants. 20% coinsurance for all other covered devices and supplies (including wound care supplies). Note: Surgical supplies such as dressings and splints, casts, and other devices used to reduce fractures and dislocations are not subject to prior authorization.
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.	You pay the following per visit, depending upon the plan in which you are enrolled: \$25 for Basic 1 plan members. \$30 for Enhanced 1 plan members.
Residential substance use disorder and mental health treatment† We cover the following services when the services are provided in a licensed residential treatment facility and above the level of custodial care:	Cost-sharing is charged for each inpatient stay.

†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.

Covered Service	What you pay
- Individual and group counseling. - Medical services. - Medication monitoring. - Room and board. - Drugs prescribed by a network provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel. - Discharge planning.	You pay the following, depending upon the plan in which you are enrolled: \$407 per day, for days 1–5 for Basic 1 plan members. \$350 per day, for days 1–5 for Enhanced 1 plan members. 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, an 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.

†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.

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 cover a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.
 Screening for sexually transmitted infections (STIs) and counseling to prevent STIs 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	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for

†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.

Covered Service	What you pay
increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Kidney disease and dialysis 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
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	20% coinsurance

†Your provider must obtain prior authorization from our plan.

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

Covered Service	What you pay
† Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care)	No additional charge for services received during a hospital stay. Refer to the "Inpatient hospital care" section of this Medical Benefits Chart for the cost-sharing applicable to inpatient stays.

Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table.

Skilled nursing facility (SNF) care†

(For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.)

We cover up to 100 days per benefit period of skilled inpatient services in a skilled nursing facility in accord with Medicare guidelines (a prior hospital stay is not required). Covered services include but aren't limited to:

- Semiprivate room (or a private room if medically necessary)
- Meals, including special diets
- Skilled nursing services
- Physical therapy, occupational therapy and speech therapy
- Drugs administered to you as part of our plan of care (this includes substances 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

You pay the following per benefit period:

- **\$0** for days 1–20.
- **\$221** per day for days 21–100.

A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or skilled nursing facility (SNF). The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 calendar days in a row.

Note: If a benefit period begins in 2026 for you and does not end until sometime in 2027, the 2026 cost-sharing will continue until the benefit period ends.

†Your provider must obtain prior authorization from our plan.

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

Covered Service	What you pay
• 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	
 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.

†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.

Covered Service	What you pay
Special Supplemental Benefits for the Chronically Ill (SSBCI) – Healthy Food The Healthy Food benefit is a Special Supplemental Benefit for the Chronically Ill available to all members who meet the criteria. Eligible members with certain chronic conditions who meet specific criteria will receive a preloaded healthy extras card with a quarterly allowance to buy approved foods, such as produce, online and at participating retail stores. The list of approved foods is subject to change. Your card will be reloaded on January 1, April 1, July 1, and October 1. Any unused portion of the quarterly allowance will not roll over to the next quarter. The cost of eligible food items will be covered up to the balance available on your card. If there is a remaining amount to pay, you must use another form of payment. Fees and minimum order requirements vary by retailers. Please review details about fees on the checkout page prior to placing an online order. You will be prompted to enter another form of payment for any tips, fees, or non-covered items. This benefit will be available only to plan-identified members who have met benefit eligibility criteria with the following conditions: • Chronic alcohol use disorder and other substance use disorders (SUDs) • Autoimmune disorders • Cancer • Cardiovascular disorders • Chronic heart failure • Dementia • Diabetes mellitus	If you qualify for SSBCI, you pay \$0 up to the following quarterly allowance, depending upon the plan in which you are enrolled: • \$100 allowance per quarter for Basic 1 plan members. • \$120 allowance per quarter for Enhanced 1 plan members. Note: This benefit is available on the same card described under “Over-the-Counter (OTC) items” 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.

Covered Service	What you pay
• Overweight, obesity, and metabolic syndrome • Chronic gastrointestinal disease • Chronic kidney disease (CKD) • Severe hematologic disorders • HIV/AIDS • Chronic lung disorders • Chronic and disabling mental health conditions • Neurologic disorders • Stroke • Post-organ transplantation care • Immunodeficiency and Immunosuppressive disorders • Conditions associated with cognitive impairment • Conditions with functional challenges and require similar services • Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell • Conditions that require continued therapy services in order for individuals to maintain or retain functioning How to use your healthy extras card To activate your healthy extras card, call 1-833-524-7035 (TTY 711), 7 days a week, 8 a.m. to 8 p.m. EST, and provide your card number and membership ID number. Once you activate your card, you may start using your card to access your allowance to purchase approved items at participating retail and online stores. If you already have a healthy extras card, you will not receive a new card. Please keep your card and your benefit will be available on your existing card.	

†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.

Covered Service	What you pay
To set up your online account, request a catalog, view a list of eligible items, find participating stores, request reimbursement, check your balance and transaction history, shop online, submit a request for reimbursement, or replace a lost or stolen card, please visit mybenefitscenter.com or call 1-833-524-7035 (TTY 711), 7 days a week, 8 a.m. to 8 p.m. EST. If you experience a problem using the card to purchase an eligible item at a participating retailer, you may complete the transaction with another form of payment and submit a reimbursement request, which will require a copy of your itemized receipt. Reimbursement requests are subject to a determination process and must be submitted within 90 days from the date of purchase on your proof of payment or receipt. You may also visit mybenefitscenter.com and download the OTC Network mobile app to find participating healthy food and OTC retailers, search for eligible items, review your transaction history and check your card balance. You can also use the OTC mobile app at stores to scan items for eligibility during shopping and view your balance before you check out. Members can download the OTC Network mobile app directly from the iTunes App Store or GooglePlay. Search “OTC Network” to download. Note: Any unused amounts are forfeited upon disenrollment from our plan.	
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.	You pay the following per visit, depending upon the plan in which you are enrolled: • \$20 for Basic 1 plan members.

†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.

Covered Service	What you pay
Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30–60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) 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.	• \$25 for Enhanced 1 plan members.
Transportation services - non-emergency routine transportation not covered by Medicare* We cover up to 18 one-way trips per calendar year to take you to and from a network provider when provided by our designated transportation provider within the service area. The one-way trips are limited to 50 miles. Rides must be scheduled at least 2 hours before your pick-up time. You must cancel rides at least 2 hours before the scheduled pick-up time. If not, the ride will be deducted from your annual ride balance. Rides are provided by taxis, rideshare services, vans, and	\$0 for 18 one-way trips per calendar year

†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.

Covered Service	What you pay
medical transport as determined by our transportation provider. To schedule a ride or find out how many rides you have left for the year (ride balance), please call 1-855-932-5414 (TTY 711), 24 hours a day, 7 days a week.	
Transportation services - non-emergency medical transportation not covered by Medicare†* We cover unlimited one-way trips per calendar year in a licensed stretcher/gurney van or wheelchair van for medically necessary, non-emergency transportation to and from medical facilities within our service area, when ordered by a network provider. Please contact Member Services at 1-800-232-4404 (TTY 711) for more information about this benefit.	• \$60 per one-way trip for wheelchair van rides • \$125 per one-way trip for stretcher and gurney van rides
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	Office visits You pay the following per visit, depending upon the plan in which you are enrolled: • \$35 for Basic 1 plan members. • \$25 for Enhanced 1 plan members. Note: If you need urgent care after your PCP's office is closed, we have outpatient facilities that provide after-hours care. Please refer to the <i>Provider Directory</i> for locations and hours of operation. Emergency Department visits

†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.

Covered Service	What you pay
network is temporarily unavailable or inaccessible due to an unusual and extraordinary circumstance (for example, major disaster). • Outside our service area: You have worldwide urgent care coverage when you travel if you need medical attention right away for an unforeseen illness or injury and you reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our service area. See Chapter 3, Section 3, for more information.	You pay the following per Emergency Department visit, depending upon the plan in which you are enrolled: • \$115 for Basic 1 plan members. • \$130 for Enhanced 1 plan members.
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.	You pay the following per visit, depending upon the plan in which you are enrolled: • \$35 for Basic 1 plan members. • \$25 for Enhanced 1 plan members.
•  For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older • For people with diabetes, screening for and monitoring of diabetic retinopathy is covered • Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. However, our plan does cover the following exams: ○ One routine eye exam (eye refraction exam) per calendar year to determine the need for vision correction and to provide a prescription for eyeglass lenses.	\$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.

Covered Service	What you pay
- One pair of eyeglasses or contact lenses (including fitting and dispensing) after each cataract surgery that includes insertion of an intraocular lens. If you have 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.	20% coinsurance for eyewear in accord with Medicare guidelines. *Note: If the eyewear you purchase costs more than what Medicare covers, you pay the difference.
Other eyewear: Once every year, we provide an allowance for you to use toward the purchase price of eyewear from a network optical facility when a network physician or optometrist prescribes eyeglasses or contact lenses for vision correction. - The allowance can be used to pay for the following items: - Eyeglass lenses when a network provider puts the lenses into a frame. - Eyeglass frames when a network provider puts two lenses (at least one of which must have refractive value) into the frame. - Contact lenses, fitting, and dispensing. - The allowance can only be used at the initial point of sale. If you do not use all of your allowance at the initial point of sale, you cannot use it later. Note: This allowance cannot be used for eyewear obtained following cataract surgery.	*If the eyewear you purchase costs more than \$500, you pay the difference.
 Welcome to Medicare preventive visit Our plan covers the one-time <i>Welcome to Medicare</i> preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain	There is no coinsurance, copayment, or deductible for the Welcome to Medicare preventive visit.

†Your provider must obtain prior authorization from our plan.

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

Covered Service	What you pay
screenings and shots (or vaccines)), and referrals for other care if needed. Important: We cover the <i>Welcome to Medicare</i> 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 <i>Welcome to Medicare</i> preventive visit.	
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.

Section 2.1 Extra optional supplemental benefits you can buy

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

The optional supplemental benefits package offered by our plan is called "Advantage Plus." You only receive the hearing aid and comprehensive dental benefits described in this section if you are enrolled in Advantage Plus. Please note that you cannot purchase just one of these benefits; they are offered together as a total package and are not available individually.

When you can enroll in Advantage Plus

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

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

Disenrollment from Advantage Plus

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

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

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
Additional monthly premium This additional monthly premium is added to your Senior Advantage plan premium (see Chapter 1, Section 4.3, for more premium information).	\$13
Hearing aid coverage*† If you are enrolled in Advantage Plus, we cover the hearing aid services listed below when prescribed by a network provider (clinical audiologist). We select the provider or vendor that will furnish the covered hearing aid. Coverage is limited to the types and models of hearing aids furnished by the provider or vendor. We cover the following: • An allowance of up to \$500 per hearing aid, per ear that you can use toward the purchase of one hearing aid every 36 months. If two aids are required to provide significant improvement that is not obtainable with only one hearing aid, we will cover one hearing aid for each ear. The \$500 allowance per ear may only be used once in any 36-month period. If you do not use all of the \$500 at the initial point of sale, you cannot use it later. Note: This hearing aid benefit is effective in the current contract year and may not be available next year.	If the hearing aid you purchase costs more than \$500, you pay the difference.
• Hearing tests to determine the appropriate hearing aid(s). • Visits to verify that the hearing aid(s) conforms to the prescription. • Visits for fitting, counseling, adjustment, cleaning, and inspection after the warranty is exhausted.	\$0

Advantage Plus

(These optional supplemental benefits only apply to members enrolled in Advantage Plus)

What you must pay*

Additional dental care (DeltaCare® USA Dental HMO Program)

We cover comprehensive dental care described below through our agreement with Delta Dental Insurance Company (“Delta Dental”) and its DeltaCare USA Medicare Plan through a network of dentists that contract with Delta Dental to provide dental services. For information about dental providers, please refer to the DeltaCare USA Medicare network “Find a dentist” page by visiting kp.org/dental/ga/medicare.

For services to be covered, members must receive dental care from their selected DeltaCare USA Medicare dentist. If a procedure isn't listed below, it isn't covered. You should discuss all treatment options with your selected dentist or dental specialist prior to receiving services. A referral may be required if a specialist is needed for your treatment plan.

You may select or change your selected dentist using your online account or contacting the Delta Dental Customer Service Center at 1-844-519-8693, Monday through Friday, 8 a.m. to 8 p.m.; October 1 – March 31, 8 a.m. to 8 p.m., 7 days a week (TTY users should call 711). A change to your selected dentist made by the 15th of the month is effective immediately. Selections made on or after the 16th of the month will be effective on the first day of the following month.

To make an appointment:

- Call your selected dentist's facility and identify yourself as a DeltaCare USA Medicare plan member.
- You can learn more about your selected dentist or select a new dentist online by visiting kp.org/dental/ga/medicare.

Diagnostic Services (D0100-D0999)

• D0364 - Cone beam CT capture and interpretation with limited field of view – less than one whole jaw <i>One (D0364, D0365, D0366 or D0367) every calendar year</i>	\$66
• D0365 - Cone beam CT capture and interpretation with field of view of one full dental arch – mandible <i>One (D0364, D0365, D0366 or D0367) every calendar year</i>	\$76

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
D0366 - Cone beam CT capture and interpretation with field of view of one full dental arch – mandible <i>One (D0364, D0365, D0366 or D0367) every calendar year</i>	\$76
D0367 - Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium <i>One (D0364, D0365, D0366 or D0367) every calendar year</i>	\$105
D0391 - Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report <i>One every calendar year</i>	\$11
Restorative Services (D2000-D2999)	
- A filling is a benefit for the removal of decay, for minor repairs of tooth structure, or to replace a lost filling. - A filling includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures. - Replacement of a filling requires the existing restoration to be 2+ years old. - Fillings are limited to no more than two procedures every calendar year (any combination of D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393 or D2394). - The fee for removal of an indirect restoration is included in the fee for any subsequent restorative procedure. - A crown is a benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional and cannot be repaired. - Replacement of crowns requires the existing restoration to be 5+ years old. - One pin retention procedure (D2951) per tooth every 2 calendar years when billed with resin or amalgam restoration. D2951 is included with D2950, D2952, D2954 if billed separately.	
D2140 - Amalgam - one surface, primary or permanent	\$21
D2150 - Amalgam - two surfaces, primary or permanent	\$27

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
• D2160 - Amalgam - three surfaces, primary or permanent	\$33
• D2161 - Amalgam - four or more surfaces, primary or permanent	\$38
• D2330 - Resin-based composite - one surface, anterior	\$20
• D2331 - Resin-based composite - two surfaces, anterior	\$24
• D2332 - Resin-based composite - three surfaces, anterior	\$29
• D2335 - Resin-based composite - four or more surfaces or involving incisal angle (anterior)	\$34
• D2390 - Resin-based composite crown, anterior	\$45
• D2391 - Resin-based composite - one surface, posterior	\$22
• D2392 - Resin-based composite - two surfaces, posterior	\$28
• D2393 - Resin-based composite - three surfaces, posterior	\$34
• D2394 - Resin-based composite - four or more surfaces, posterior	\$38
• D2915 - Re-cement or re-bond indirectly fabricated or prefabricated post and core <i>One recement (D2915 or D2920) per tooth every 2 calendar years</i>	\$12

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
• D2920 - Re-cement or re-bond crown <i>One recement (D2915 or D2920) per tooth every 2 calendar years</i>	\$13
• D2928 - Prefabricated porcelain/ceramic crown – permanent tooth <i>One per tooth every 2 calendar years</i>	\$39
• D2940 - Protective restoration <i>One per tooth per lifetime</i>	\$13
• D2951 - Pin retention - per tooth, in addition to restoration <i>One per tooth every 2 calendar years</i>	\$7
Endodontic Services (D3000-D3999)	
• Root canals and retreatments are limited to no more than two every calendar year (any combination of D3310, D3320, D3330, D3346, D3347 or D3348) • Placement of interim direct restoration is included in the fee for all covered endodontic procedures (D3220-D3950) when done on the same date by the same dentist/dental office. • Retreatment of root canal therapy when performed by the same dentist/dental office within 2 calendar years is included in the fee for the original treatment; however, when performed by a different dentist, it is not covered. • A direct or indirect pulp cap is a benefit only on a vital permanent tooth with an open apex or a vital primary tooth. • With the exception of pulp caps and pulpotomies, endodontic procedures (e.g., root canal therapy, apicoectomy, retrofill, etc.) are only a benefit on a permanent tooth with pathology. • A therapeutic pulpotomy on a permanent tooth is limited to palliative treatment when the dentist is not performing root canal therapy.	
• D3110 - Pulp cap - direct (excluding final restoration)	\$9
• D3120 - Pulp cap - indirect (excluding final restoration)	\$9

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
• D3220 - Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament <i>One (D3220 or D3321) per tooth per lifetime</i>	\$22
• D3221 - Pulpal debridement, primary and permanent teeth <i>One (D3220 or D3321) per tooth per lifetime</i>	\$32
• D3310 - Endodontic therapy, anterior tooth (excluding final restoration) <i>One root canal (D3310, D3320 or D3330) per tooth per lifetime</i>	\$126
• D3320 - Endodontic therapy, premolar tooth (excluding final restoration) <i>One root canal (D3310, D3320 or D3330) per tooth per lifetime</i>	\$144
• D3330 - Endodontic therapy, molar tooth (excluding final restoration) <i>One root canal (D3310, D3320 or D3330) per tooth per lifetime</i>	\$195
• D3331 - Treatment of root canal obstruction; non-surgical access	\$65
• D3346 - Retreatment of previous root canal therapy - anterior <i>One retreatment (D3346, D3347 or D3348) per tooth every 2 calendar years</i>	\$181
• D3347 - Retreatment of previous root canal therapy - premolar <i>One retreatment (D3346, D3347 or D3348) per tooth every 2 calendar years</i>	\$203

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
• D3348 - Retreatment of previous root canal therapy - molar <i>One retreatment (D3346, D3347 or D3348) per tooth every 2 calendar years</i>	\$250
• D3410 - Apicoectomy - anterior <i>One per tooth per lifetime</i>	\$166
• D3421 - Apicoectomy - premolar (first root) <i>One per tooth per lifetime</i>	\$182
• D3425 - Apicoectomy - molar (first root) <i>One per tooth per lifetime</i>	\$199
• D3426 - Apicoectomy (each additional root) <i>One per tooth per lifetime</i>	\$53
• D3430 - Retrograde filling - per root <i>One per tooth per lifetime</i>	\$44
• D3450 - Root amputation - per root <i>One per tooth per lifetime</i>	\$108
Periodontic Services (D4000-D4999) • Includes pre-operative and post-operative evaluations and treatment under a local anesthetic. • If you have not had regular dental visits (at least once every 6 months) or have been diagnosed with gum disease, you may need periodontal scaling and root planing, or full-mouth debridement before routine care such as regular cleanings can be provided.	
• D4210 - Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant <i>One (D4210 or D4211) per quadrant every 3 calendar years</i>	\$91

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
• D4211 - Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant <i>One (D4210 or D4211) per quadrant every 3 calendar years</i>	\$43
• D4240 - Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant <i>One (D4240 or D4241) per quadrant every 3 calendar years</i>	\$109
• D4241 - Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant <i>One (D4240 or D4241) per quadrant every 3 calendar years</i>	\$108
• D4249 - Clinical crown lengthening - hard tissue <i>One per permanent tooth per lifetime</i>	\$120
• D4260 - Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant <i>One (D4260 or D4261) per quadrant every 3 calendar years</i>	\$257
• D4261 - Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant <i>One (D4260 or D4261) per quadrant every 3 calendar years</i>	\$189
• D4266 - Guided tissue regeneration, natural teeth - resorbable barrier, per site <i>One (D4266 or D4267) per tooth every 3 calendar years</i>	\$107

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
• D4267 - Guided tissue regeneration, natural teeth - non-resorbable barrier, per site <i>One (D4266 or D4267) per tooth every 3 calendar years</i>	\$102
• D4355 - Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit <i>One every 2 calendar years</i>	\$17
• D4381 - Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth <i>One per tooth every 2 calendar years</i>	\$9
Prosthodontic, removable (D5000-D5999)	
• For all listed dentures and partial dentures, the copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, the copayment includes after delivery adjustments and tissue conditioning, if needed, for the first three months after placement. You must continue to be eligible, and the service must be provided at the same dentist's facility where the denture was originally delivered. • Replacement of a denture, partial denture or overdenture requires the existing denture to be 5+ years old. • The replacement of a removable partial denture with a full denture is covered within the 5-year frequency limitation period when natural teeth are lost. • Interim partial dentures (stayplates) are limited to the replacement of extracted anterior teeth for adults during a healing period.	
• D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) <i>One partial maxillary denture every 5 calendar years</i>	\$118

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
• D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) <i>One partial mandibular denture every 5 calendar years</i>	\$115
• D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) <i>One partial maxillary denture every 5 calendar years</i>	\$169
• D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) <i>One partial mandibular denture every 5 calendar years</i>	\$171
• D5227 - Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth) <i>One partial maxillary denture every 5 calendar years</i>	\$158
• D5228 - Immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth) <i>One partial mandibular denture every 5 calendar years</i>	\$146
• D5511 - Repair broken complete denture base, mandibular <i>One every calendar year</i>	\$23
• D5512 - Repair broken complete denture base, maxillary <i>One every calendar year</i>	\$23
• D5520 - Replace missing or broken teeth - complete denture (each tooth) <i>One every calendar year</i>	\$19

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
• D5611 - Repair resin partial denture base, mandibular <i>One (D5611 or D5621) every calendar year</i>	\$22
• D5612 - Repair resin partial denture base, maxillary <i>One (D5612 or D5622) every calendar year</i>	\$22
• D5621 - Repair cast partial framework, mandibular <i>One (D5611 or D5621) every calendar year</i>	\$28
• D5622 - Repair cast partial framework, maxillary <i>One (D5612 or D5622) every calendar year</i>	\$26
• D5630 - Repair or replace broken retentive/clasping materials - per tooth <i>One (D5610 - D5660) every calendar year</i>	\$26
• D5640 - Replace broken teeth - per tooth <i>One (D5610 - D5660) every calendar year</i>	\$21
• D5650 - Add tooth to existing partial denture <i>One (D5610 - D5660) every calendar year</i>	\$23
• D5660 - Add clasp to existing partial denture - per tooth <i>One (D5610 - D5660) every calendar year</i>	\$26
• D5710 - Rebase complete maxillary denture <i>One every 2 calendar years</i>	\$58
• D5711 - Rebase complete mandibular denture <i>One every 2 calendar years</i>	\$56
• D5720 - Rebase maxillary partial denture <i>One every 2 calendar years</i>	\$55

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
• D5721 - Rebase mandibular partial denture <i>One every 2 calendar years</i>	\$57
• D5730 - Reline complete maxillary denture (direct) <i>Two (D5730, D5740, D5750, D5760 or D5765) per calendar year</i>	\$37
• D5731 - Reline complete mandibular denture (direct) <i>Two (D5731, D5741, D5751, D5761 or D5765) per calendar year</i>	\$35
• D5740 - Reline maxillary partial denture (direct) <i>Two (D5730, D5740, D5750, D5760 or D5765) per calendar year</i>	\$33
• D5741 - Reline mandibular partial denture (direct) <i>Two (D5731, D5741, D5751, D5761 or D5765) per calendar year</i>	\$34
• D5750 - Reline complete maxillary denture (indirect) <i>Two (D5730, D5740, D5750, D5760 or D5765) per calendar year</i>	\$49
• D5751 - Reline complete mandibular denture (indirect) <i>Two (D5731, D5741, D5751, D5761 or D5765) per calendar year</i>	\$49
• D5760 - Reline maxillary partial denture (indirect) <i>Two (D5730, D5740, D5750, D5760 or D5765) per calendar year</i>	\$48
• D5761 - Reline mandibular partial denture (indirect) <i>Two (D5731, D5741, D5751, D5761 or D5765) per calendar year</i>	\$48

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
D5765 - Soft liner for complete or partial removable denture - indirect <i>Two (D5730, D5740, D5750, D5760, D5765, D5731, D5741, D5751 or D5761) per calendar year</i>	\$45
Implant Services (D6000-D6199)	
- The following are limited to no more than two (2) each per calendar year: implant placements, implant supported prosthetics, and implant abutments. - Replacement of implants, abutments, crowns, bridges, and implant supported dentures requires the existing restoration to be 5+ years old. - Name brand, laboratory processed, or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The dentist may charge an additional fee not to exceed \$150 in addition to the copayment listed below. Refer to Section 3.1, "Dental limitations and exclusions," for additional information. - If any existing fixed bridge or removable denture would be replaced by a new implant-supported prosthesis, that existing appliance must be eligible for replacement under this benefit. - You must be at least 19 years old to receive implant services. - Implants and implant supported crowns and prosthesis are covered to replace one or more natural permanent teeth lost due to accidental trauma or removal.	
D6010 - Surgical placement of implant body: endosteal implant	\$820
D6011 - Surgical access to an implant body (second stage implant surgery)	\$88
D6013 - Surgical placement of mini implant	\$319
D6040 - Surgical placement: eposteal implant	\$932
D6050 - Surgical placement: transosteal implant	\$522

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
D6056 - Prefabricated abutment – includes modification and placement	\$197
D6057 - Custom fabricated abutment – includes placement	\$261
D6058 - Abutment supported porcelain/ceramic crown	\$424
D6059 - Abutment supported porcelain fused to metal crown (high noble metal)	\$440
D6060 - Abutment supported porcelain fused to metal crown (predominantly base metal)	\$350
D6061 - Abutment supported porcelain fused to metal crown (noble metal)	\$378
D6062 - Abutment supported cast metal crown (high noble metal)	\$409
D6063 - Abutment supported cast metal crown (predominantly base metal)	\$387
D6064 - Abutment supported cast metal crown (noble metal)	\$351
D6065 - Implant supported porcelain/ceramic crown	\$435
D6066 - Implant supported crown - porcelain fused to high noble alloys	\$461
D6067 - Implant supported crown - high noble alloys	\$462

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
D6068 - Abutment supported retainer for porcelain/ceramic FPD	\$399
D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	\$404
D6070 - Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	\$326
D6071 - Abutment supported retainer for porcelain fused to metal FPD (noble metal)	\$324
D6072 - Abutment supported retainer for cast metal FPD (high noble metal)	\$398
D6073 - Abutment supported retainer for cast metal FPD (predominantly base metal)	\$335
D6074 - Abutment supported retainer for cast metal FPD (noble metal)	\$388
D6075 - Implant supported retainer for ceramic FPD	\$417
D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys	\$426
D6077 - Implant supported retainer for metal FPD - high noble alloys	\$469
D6082 - Implant supported crown - porcelain fused to predominantly base alloys	\$344
D6092 - Re-cement or re-bond implant/abutment supported crown <i>One per arch every calendar year</i>	\$41

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
• D6093 - Re-cement or re-bond implant/abutment supported fixed partial denture <i>One per arch every calendar year</i>	\$50
• D6094 - Abutment supported crown - titanium and titanium alloys	\$425
• D6096 - Remove broken implant retaining screw <i>One per tooth every 5 calendar years</i>	\$90
• D6110 - Implant/abutment supported removable denture for edentulous arch – maxillary	\$520
• D6111 - Implant/abutment supported removable denture for edentulous arch – mandibular	\$539
• D6112 - Implant/abutment supported removable denture for partially edentulous arch – maxillary	\$585
• D6113 - Implant/abutment supported removable denture for partially edentulous arch – mandibular	\$701
• D6114 - Implant/abutment supported fixed denture for edentulous arch – maxillary	\$1,848
• D6115 - Implant/abutment supported fixed denture for edentulous arch – mandibular	\$2,000
• D6116 - Implant/abutment supported fixed denture for partially edentulous arch – maxillary	\$1,433
• D6117 - Implant/abutment supported fixed denture for partially edentulous arch – mandibular	\$2,000

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
• D6190 - Radiographic/surgical implant index, by report <i>One per arch every 5 calendar years</i>	\$147
• D6194 - Abutment supported retainer crown for FPD – titanium and titanium alloys <i>One every calendar year</i>	\$431
Oral and Maxillofacial Surgery (D7000-D7999)	
• Includes pre-operative and post-operative evaluations and treatment under a local anesthetic. • Extractions are limited to three every calendar year (any combination of D7140, D7210, D7220, D7230, D7240, D7241, D7250 or D7251). • Nerve dissection is included in the fee for the removal of an impacted tooth, complete bony, with unusual surgical complications, as part of that extraction procedure. Otherwise, nerve dissection is not covered.	
• D7140 - Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$21
• D7210 - Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$45
• D7220 - Removal of impacted tooth - soft tissue	\$55
• D7230 - Removal of impacted tooth - partially bony	\$73
• D7240 - Removal of impacted tooth - completely bony	\$86

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
• D7241 - Removal of impacted tooth - completely bony, with unusual surgical complications	\$99
• D7250 - Removal of residual tooth roots (cutting procedure)	\$50
• D7251 - Coronectomy - intentional partial tooth removal, impacted teeth only	\$97
• D7270 - Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth <i>One per tooth per lifetime</i>	\$57
• D7280 - Exposure of an unerupted tooth <i>One per tooth per lifetime</i>	\$98
• D7282 - Mobilization of erupted or malpositioned tooth to aid eruption <i>One per tooth per lifetime</i>	\$59
• D7284 - Excisional biopsy of minor salivary glands <i>One in same day</i>	\$76
• D7286 - Incisional biopsy of oral tissue – soft <i>One per day</i>	\$69
• D7288 - Brush biopsy - transepithelial sample collection <i>One every calendar year</i>	\$23
• D7310 - Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant <i>One (D7310 or D7311) per quadrant per lifetime</i>	\$42

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
• D7311 - Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant <i>One (D7310 or D7311) per quadrant per lifetime</i>	\$38
• D7320 - Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant <i>One (D7320 or D7321) per quadrant per lifetime</i>	\$67
• D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant <i>One (D7320 or D7321) per quadrant per lifetime</i>	\$50
• D7340 - Vestibuloplasty - ridge extension (secondary epithelialization) <i>One per arch per lifetime</i>	\$112
• D7350 - Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) <i>One per arch per lifetime</i>	\$184
• D7450 - Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm <i>One per day</i>	\$119
• D7451 - Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm <i>One per day</i>	\$196
• D7471 - Removal of lateral exostosis (maxilla or mandible) <i>One per quadrant per lifetime</i>	\$140
• D7472 - Removal of torus palatinus <i>One per arch per lifetime</i>	\$174

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
• D7473 - Removal of torus mandibularis <i>One per quadrant per lifetime</i>	\$146
• D7510 - Incision and drainage of abscess - intraoral soft tissue <i>One per day</i>	\$34
• D7953 - Bone replacement graft for ridge preservation - per site <i>One in a lifetime per site</i>	\$94
• D7970 - Excision of hyperplastic tissue - per arch <i>One per arch per lifetime</i>	\$98
• D7971 - Excision of pericoronal gingiva <i>One per tooth per lifetime</i>	\$43
Adjunctive General Services (D9000-D9999)	
• A maximum of 60 minutes of either general anesthesia or intravenous moderate sedation is allowed per date of service. Additional units are not covered. • General anesthesia and intravenous moderate (conscious) sedation is a benefit only when provided by a dentist in conjunction with covered oral surgery procedures or selected endodontic and periodontal surgical procedures. Benefits are limited to one type of anesthesia per day.	
• D9222 - Deep sedation/general anesthesia – first 15 minutes	\$40
• D9223 - Deep sedation/general anesthesia – each subsequent 15 minute increment	\$38
• D9224 - Administration of general anesthesia with advanced airway - first 15 minute increment, or any portion thereof	\$40

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
• D9225 - Administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof.	\$38
• D9230 - Inhalation of nitrous oxide/analgesia, anxiolysis <i>Three every calendar year</i>	\$9
• D9239 - Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	\$36
• D9243 - Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	\$32
• D9244 - In-office administration of minimal sedation – single drug – enteral <i>Three (D9244, D9245, D9246 or D9247) every calendar year</i>	\$29
• D9245 - In-office administration of minimal sedation – single drug – enteral <i>Three (D9244, D9245, D9246 or D9247) every calendar year</i>	\$29
• D9310 - Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician <i>One per lifetime per provider</i>	\$27
• D9430 - Office visit for observation (during regularly scheduled hours) – no other services performed	\$9
• D9440 - Office visit – after regularly scheduled hours <i>One every calendar year</i>	\$22
• D9951 - Occlusal adjustment – limited <i>One every 5 calendar years</i>	\$18

Advantage Plus (These optional supplemental benefits only apply to members enrolled in Advantage Plus)	What you must pay*
D9952 - Occlusal adjustment – complete <i>One every 5 calendar years</i>	\$60
D9975 - External bleaching for home application, per arch; includes materials and fabrication of custom trays <i>limited to one bleaching tray and gel for two weeks of self-treatment</i>	\$22

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

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

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

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

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances
Care in an intermediate or residential care facility, assisted living facility, or adult foster home	Covered as described in "Residential substance use disorder and mental health treatment" section of the Medical Benefits Chart.
Conception by artificial means, such as in vitro fertilization, zygote intrafallopian transfers, ovum transplants, and gamete intrafallopian transfers (except	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
artificial insemination and related services covered by Medicare)	
Cord blood procurement and storage for possible future need	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 and covered under Original Medicare.
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	May be covered by Original Medicare under a Medicare-approved clinical research study. (Go to Chapter 3, Section 5 for more information on clinical research studies)

Services not covered by Medicare	Covered only under specific conditions
The following eyewear services and items: • Lens protection plan. • Nonprescription products. • Industrial or safety lenses and frames. • Lenses and sunglasses without refractive value, except that this exclusion doesn't apply to a clear balance lens if only one eye needs correction or tinted lenses when medically necessary to treat macular degeneration or retinitis pigmentosa. • Replacement of lost, broken, or damaged lenses or frames. • Eyeglass or contact lens adornment. • Eyewear items that do not require a prescription by law (other than eyeglass frames or a covered balance lens).	Not covered under any condition Note: One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens. See Vision care in the Medical Benefits Chart for more information.
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Hearing aids or exams to fit hearing aids	This exclusion doesn't apply to cochlear implants and osseointegrated external hearing devices covered by Medicare. This exclusion also doesn't apply if you are enrolled in optional supplemental benefits described in Section 2.1 of this chapter. The optional supplemental hearing aid benefits are subject to the following exclusions:

Services not covered by Medicare	Covered only under specific conditions
	• Internally implanted hearing aids. • Replacement parts, accessories, batteries, repair of hearing aids, and replacement of lost or broken hearing aids. • Service packages that include adjustment, cleaning, and inspection of hearing aids after manufacturer's warranty. • Hearing aids prescribed or ordered before you were enrolled in optional supplemental benefits.
Home-delivered meals	Covered in limited situations as described in the Medical Benefits Chart.
Homemaker services include basic household help, including light housekeeping or light meal preparation	Not covered under any condition
Licensed ambulance services without transport	Covered if the ambulance transports you or if covered by Medicare.
Massage therapy	Covered when ordered as part of physical therapy program in accord with Medicare guidelines.
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Nonconventional intraocular lenses (IOLs) following cataract surgery (for example, a presbyopia-correcting IOL)	Not covered under any condition
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
Physical exams and other services (1) required for obtaining or maintaining employment or participation in employee programs, (2) required for insurance or licensing, or (3) on court order or required for parole or probation	Covered if a network physician determines that the services are medically necessary or medically appropriate preventive care.
Private duty nursing	Not covered under any condition
Private room in a hospital	Covered only when medically necessary
Psychological testing for ability, aptitude, intelligence, or interest	Not covered under any condition
Radial keratotomy, LASIK surgery, and other low-vision aids	Not covered under any condition
Reconstructive surgery that offers only a minimal improvement in appearance or is performed to alter or reshape normal structures of the body in order to improve appearance	We cover reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defect, developmental abnormalities, accidental injury, trauma, infection, tumors, or disease, if a network physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible.
Reversal of sterilization procedures and non-prescription contraceptive supplies	Not covered under any condition
Routine chiropractic care	Manual manipulation of the spine to correct a vertebral subluxation is covered
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)
Services considered not reasonable and necessary, according to Original Medicare standards	This exclusion doesn't apply to services or items that aren't covered by Original Medicare but are covered by our plan.

Services not covered by Medicare	Covered only under specific conditions
Services provided to veterans in Veterans Affairs (VA) facilities	When emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our plan's cost-sharing amounts.
Services related to noncovered services or items	When a service or item is not covered, all services related to the noncovered service or item are excluded, (1) except for services or items we would otherwise cover to treat complications of the noncovered service or item, or (2) unless covered in accord with Medicare guidelines.
Services to reverse voluntary, surgically induced infertility	Not covered under any condition
Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a network provider	Covered as described in "Transportation services - non-emergency medical transportation not covered by Medicare" section of the Medical Benefits Chart.
Travel and lodging expenses	We may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines.

Section 3.1 Dental limitations and exclusions

The limitations and exclusions in this section apply to the dental services described in the Medical Benefits Chart or Advantage Plus chart unless otherwise indicated.

Limitations

1. The frequency of certain benefits is limited. All frequency limitations are listed in the Medical Benefits Chart or Advantage Plus chart.
2. When recommending covered crown(s), bridge pontic(s) and/or bridge retainers, which are supported either by a natural tooth or dental implant, your dentist may offer services that utilize brand or trade names at an additional fee. You must be offered the high quality laboratory processed crown/pontic that may include: porcelain/ceramic; porcelain with base, noble or high-noble metal. If you choose the alternative of a

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

material upgrade (name brand laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials, including but not limited to: Captek, Procera, Lava, Empress and Cerec), your dentist may charge an additional fee not to exceed \$150 in addition to the copayments listed in the Medical Benefits Chart or Advantage Plus chart.

3. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:
 - a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, and was placed five or more years prior to its replacement, or
 - b. An existing partial denture is less than five years old, but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture, or
 - c. An existing fixed partial denture (bridge) is less than 5 years old, but must be replaced by a new fixed partial denture due to the loss of the natural tooth.
4. For emergency dental care, if the following conditions are not met, you are responsible for the full cost of the dental care:
 - a. You made a reasonable attempt to contact your assigned DeltaCare USA Medicare dentist and you cannot be seen within 24 hours or you believe that your condition makes it unreasonable or impossible to travel to your assigned DeltaCare USA Medicare dentist. If you are a new member without a selected dentist yet, you should contact Delta Dental Customer Service for help in locating a DeltaCare USA Medicare dentist.
 - b. You called Delta Dental Customer Service prior to receiving emergency dental care, or it is reasonable for you to get emergency dental care without calling Customer Service considering your condition and the circumstances.
 - c. Claims for covered emergency dental services must be submitted to Delta Dental within 90 days of the treatment date unless you can prove that it was not reasonably possible to submit the claim within that time. In which case, the claim must be received within 1 year of the treatment date. Send your claim to: Delta Dental Claims Department, P.O. Box 1803, Alpharetta, GA 30023.

Exclusions

1. Any procedure that is not specifically listed in the Medical Benefits Chart or Advantage Plus chart.
2. Any procedure that in the professional opinion of the dentist or Delta Dental clinical staff:
 - a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or

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- b. is inconsistent with generally accepted standards for dentistry, or
 - c. services considered inclusive or part of another procedure cannot be charged separately.
- 3. Services solely for cosmetic purposes, or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing or unerupted teeth, and teeth that are discolored or lacking enamel.
- 4. Restorations placed solely due to wear, abrasion, attrition, or erosion.
- 5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
- 6. Procedures, appliances or restorations if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
- 7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
- 8. Consultations for non-covered benefits.
- 9. Dental services received from any dental facility other than the assigned Deltacare HMO Medicare dentist. This includes the services of an out-of-network dental specialist, unless expressly authorized by Delta Dental except for emergency services.
- 10. All related fees for admission, use, or stays in a hospital, outpatient surgery center, extended care facility, or other similar care facility.
- 11. Prescription drugs.
- 12. Dental expenses incurred in connection with any dental procedure started before your eligibility with the DeltaCare USA Medicare HMO program. Examples include teeth prepared for crowns, root canals in progress and full or partial dentures for which an impression has been taken.
- 13. Treatment or appliances that are provided by a dentist whose practice specializes in prosthodontic services.
- 14. Services or supplies for sleep apnea.
- 15. Administration of neuromodulators.
- 16. Administration of dermal fillers.
- 17. Photobiomodulation therapy.

CHAPTER 5:

Using plan coverage for Part D drugs

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

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

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription, that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription (go to Section 2), or you can fill your prescription through our plan's mail-order service.
- Your drug must be on our plan's *2027 Comprehensive Formulary* (go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 in this chapter for more information)

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

In most cases, your prescriptions are covered only if they're filled at our plan's network pharmacies. (Go to Section 2.4 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 that are on our plan's Drug List.

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Pharmacy Directory*, visit our website (kp.org/directory), and/or call Member Services at 1-800-232-4404 (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 1-800-232-4404 (TTY users call 711) or use the *Pharmacy Directory*. You can also find information on our website at kp.org/directory.

Specialized pharmacies

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting Part D drugs in an LTC facility, call Member Services at 1-800-232-4404 (TTY users call 711).
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network. I/T/U pharmacies must be within our service area.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. To locate a specialized pharmacy, go to your *Pharmacy Directory* (kp.org/directory) or call Member Services at 1-800-232-4404 (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 100-day supply.

To get order forms and information about filling your prescriptions by mail, visit our website at kp.org/refill or call Member Services at 1-404-233-3700 (TTY 711), 7 days a week, 8 a.m. to 8 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 1-770-434-2008 or toll free at 1-888-662-4579 (TTY 711), Monday through Friday, 8 a.m. to 5 p.m.

- For new prescriptions, you can mail your provider's prescription to our mail-order pharmacy at the following address: Kaiser Permanente Mail Order Pharmacy, P.O. Box 34383, Seattle, WA 98124-1383. You'll need to include our new prescription order form, which is available at kp.org.

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 Kaiser Permanente Pharmaceutical Services for assistance at 1-770-496-3787 (TTY 711), 9 a.m. to 7 p.m., Monday through Friday, and 9 a.m. to 6 p.m., Saturday and Sunday. Also, if you can't wait for your prescription to arrive from our mail-order pharmacy, you can get an urgent supply by calling your local network retail pharmacy listed in your *Pharmacy Directory* or at kp.org/directory. Please be aware that you may pay more if you get a 100-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.

You also have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, contact your pharmacy 5 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact us by:

- Calling Pharmaceutical Services for assistance at 1-770-496-3787 (TTY 711), 9 a.m. to 7 p.m., Monday through Friday, and 9 a.m. to 6 p.m., Saturday and Sunday for help; or
- Visiting our website at kp.org/refill and follow these steps:

View Pharmacy → Auto Refill → Manage Auto Refill → Remove this medication from Auto Refill

If you get a refill automatically by mail that you don't want, you may be eligible for a refund.

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

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

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Pharmacy Directory* (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 1-800-232-4404 (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 1-800-232-4404 (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're 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'll 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'll 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're 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're 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're 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 *2027 Comprehensive Formulary*. In this *Evidence of Coverage*, we call it the Drug List.

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare. The Drug List only shows drugs covered under Medicare Part D.

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

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

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

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

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

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

Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

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

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

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

- Cost-sharing **Tier 1** for preferred generic drugs (this tier includes some brand-name drugs).
- Cost-sharing **Tier 2** for generic drugs (this tier includes some brand-name drugs).
- Cost-sharing **Tier 3** for preferred brand-name drugs (this tier includes both generic and brand-name drugs).
- Cost-sharing **Tier 4** for nonpreferred drugs (this tier includes both generic and brand-name drugs).
- Cost-sharing **Tier 5** for specialty-tier drugs (this tier includes both generic and brand-name drugs).
- Cost-sharing **Tier 6** for 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 (*2027 Comprehensive Formulary*) on the website is always the most current.
- Call Member Services at 1-800-232-4404 (TTY users call 711) to find out if a particular drug is on our plan's Drug List (*2027 Comprehensive Formulary*) or ask for a copy of the list.

- Use our plan's "Real-Time Benefit Tool" (kp.org/seniorrx) to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Member Services at 1-800-232-4404 (TTY users call 711).

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

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

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

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

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Member Services at 1-800-232-4404 (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 1-800-232-4404 (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 that isn't on our Drug List has restrictions. For example:

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

If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.

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

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

You may be able to get a temporary supply

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

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

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

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

For questions about a temporary supply, call Member Services at 1-800-232-4404 (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 1-800-232-4404 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

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

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

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

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Member Services at 1-800-232-4404 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

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

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

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

SECTION 6 Our Drug List can change during the year

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

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

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

Information on changes to drug coverage

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

Changes to drug coverage that affect you during this plan year

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

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

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

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

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

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

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

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

SECTION 7 Types of drugs we don't cover

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

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

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

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.

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

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

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

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 your drug cost. You need to pay the pharmacy your share of the cost when you pick up your prescription.

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

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

SECTION 9 Part D drug coverage in special situations

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

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

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

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

Check your *Pharmacy Directory* (kp.org/directory) to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Member Services at 1-800-232-4404 (TTY users call 711). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

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

Section 9.3 If you also have drug coverage from an employer or retiree group plan

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

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage pays first.

Special note about creditable coverage:

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

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

Keep any notices about creditable coverage because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice,

ask for a copy from your employer or retiree plan's benefits administrator or the employer or union.

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

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

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

SECTION 10 Programs on drug safety and managing medications

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

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

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

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

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

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had

a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

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

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

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

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

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

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

results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will get information on the safe disposal of prescription medications that are controlled substances.

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

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Member Services at 1-800-232-4404 (TTY users call 711).

CHAPTER 6:

What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

If you're in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs does not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call Member Services at 1-800-232-4404 (TTY users call 711) and ask for the *LIS Rider*.

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

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 at (kp.org/seniorrx), the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided by the “Real-Time Benefit Tool” by calling Member Services at 1-800-232-4404 (TTY users call 711).

This *Evidence of Coverage* describes the following Senior Advantage plans and they all include Medicare Part D prescription drug coverage:

- Basic 1 plan
- Enhanced 1 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).

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

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

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

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

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

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

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

- The amount you pay for drugs when you're in the following drug payment stages:
 - 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 **\$2,400** in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

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

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

- Your monthly plan premium
- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by our plan
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs and vaccines covered by Part A or Part B and other drugs excluded from coverage by Medicare

- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling Member Services at 1-800-232-4404 (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 \$2,400, the *Part D EOB* will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up-to-date.

SECTION 2 Drug payment stages for our plan members

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

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

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

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

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

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

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

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

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

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

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
 - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
 - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
 - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
 - If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
 - **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket

costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.

- **Check the written report we send you.** When you get the *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or you have questions, call Member Services at 1-800-232-4404 (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 There is no deductible for Kaiser Permanente Senior Advantage

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

SECTION 5 The Initial Coverage Stage

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

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

Our plan has 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).
- 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). You pay \$35 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 \$35 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 \$35 per month supply of each covered insulin product on this tier.

- Cost-sharing **Tier 6** for Part D vaccines (this tier includes only brand-name drugs).

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

Your pharmacy choices

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

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

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

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

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

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

	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.)
Tier	(up to a 30- day supply)	(up to a 30- day supply)	(up to a 31- day supply)	(up to a 30- day supply)
Tier 1 – Preferred generic drugs	\$0			

	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.)
Tier	(up to a 30- day supply)	(up to a 30- day supply)	(up to a 31- day supply)	(up to a 30- day supply)
(All Plans)				
Tier 2 – Generic drugs (All Plans)	\$0			
Tier 3 – Preferred brand-name drugs* (All Plans)	\$47			
Tier 4 – Nonpreferred drugs* (All Plans)	\$100			
Tier 5 – Specialty-tier drugs*	30% coinsurance			
• Basic 1				
• Enhanced 1	32% coinsurance			
Tier 6 – Part D vaccines (All Plans)	\$0	Mail order isn’t available for drugs in Tier 6.	\$0	

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

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

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

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

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

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 100-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 100-day supply.

- 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 long-term (up to a 100-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 100-day supply	31- to 60-day supply	61- to 100-day supply
Tier 1 – Preferred generic drugs (All Plans)	\$0			
Tier 2 – Generic drugs (All Plans)	\$0			
Tier 3 – Preferred brand-name drugs* (All Plans)	\$94	\$141	\$94	
Tier 4 – Nonpreferred drugs* (All Plans)	\$200	\$300	\$200	

Tier	Retail cost-sharing (in-network)		Mail-order cost-sharing	
	31- to 60-day supply	61- to 100-day supply	31- to 60-day supply	61- to 100-day supply
Tier 5 – Specialty-tier drugs*	30% coinsurance			
• Basic 1 • Enhanced 1	32% coinsurance			
Tier 6 – Part D vaccines (All Plans)	A long-term supply isn’t available for drugs in Tier 6.			

*You won’t pay more than:

- \$70 for up to a 2-month supply of Tiers 3–5 drugs or
- \$94 for up to a 3-month supply for Tier 3 mail order drugs or \$105 for up to a three-month supply for Tier 3 retail drugs or Tiers 4–5 drugs of each covered insulin product regardless of the cost-sharing tier.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach \$2,400

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach \$2,400. You then move to the Catastrophic Coverage Stage.

The *Part D EOB* you get will help you keep track of how much you, our plan, and any third parties have spent on your behalf during the year. Not all members will reach the \$2,400 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 \$2,400 limit for the calendar year. Once you’re in the Catastrophic Coverage Stage, you’ll stay in this payment stage until the end of the calendar year.

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

SECTION 7 What you pay for Part D vaccines

Important message about what you pay for vaccines –Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan’s 2027 Comprehensive Formulary. Our plan covers most adult Part D vaccines at no cost to you.

Go to our plan’s *2027 Comprehensive Formulary* or call Member Services at 1-800-232-4404 (TTY users call 711) for coverage and cost-sharing details about specific vaccines.

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

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

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

1. Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).

- Most adult Part D vaccines are recommended by ACIP and cost you nothing.

2. Where you get the vaccine.

- The vaccine itself may be dispensed by a pharmacy or provided by the doctor’s office.

3. Who gives you the vaccine.

- A pharmacist or another provider may give the vaccine in the pharmacy. Or a provider may give it in the doctor’s office.

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

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

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

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

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

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

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

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

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

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

CHAPTER 7:

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

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

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

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

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

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

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

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

- If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.

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

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

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

3. If you're retroactively enrolled in our plan

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- You don't have to use the form, but it will help us process the information faster.
- You can file a claim to request payment by completing and submitting our electronic form at kp.org and upload supporting documentation.

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

- Download a copy of the form from our website (kp.org) or call Member Services at 1-800-232-4404 and ask them to send you the form. Mail the completed form to our Claims Department address listed below.
- If you are unable to get the form, you can file your request for payment by sending us the following information to our Claims Department address listed below.
 - A statement with the following information:
 - Your name (member/patient name) and medical/health record number.
 - The date you received the services.
 - Where you received the services.
 - Who provided the services.
 - Why you think we should pay for the services.
 - Your signature and date signed. (If you want someone other than yourself to make the request, we will also need a completed “Appointment of Representative” form, which is available at kp.org.)
 - A copy of the bill, your medical record(s) for these services and your receipt if you paid for the services.

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

Kaiser Permanente
Claims Department
Georgia Region
P.O. Box 370010
Denver, CO 80237-9998

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

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

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

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

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

CHAPTER 8:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in large font, braille, audio file, or data file at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at 1-800-232-4404 (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 1-800-232-4404 (TTY users call 711). You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

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

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

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

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

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

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

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

How do we protect the privacy of your health information?

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

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

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

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

If you have questions or concerns about the privacy of your personal health information, call Member Services at 1-800-232-4404 (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 1-800-232-4404 (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 is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug isn't covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

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

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

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

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

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

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

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

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

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Member Services at 1-800-232-4404 (TTY users call 711) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.

- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the Georgia Department of Human Resources. You may contact the Georgia Department of Human Resources at 1-404-656-5680.

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 Member Services at 1-800-232-4404 (TTY users call 711)**

- **Call your local SHIP at 1-866-552-4464** (select option 4 when prompted)
- **Call Medicare at 1-800-MEDICARE (1-800-633-4227)** (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call our plan's Member Services at 1-800-232-4404 (TTY users call 711)**
- **Call your local SHIP at 1-866-552-4464** (select option 4 when prompted)
- **Contact Medicare**
 - Visit [Medicare.gov](https://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 1-800-232-4404 (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 1-800-232-4404 (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 a premium for your Medicare Part B to stay a member of our plan.
 - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
 - If you're required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to stay a member of our plan.
- **If you move *within* 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 2 types of processes for handling problems and concerns:

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

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

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

Section 1.1 Legal terms

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

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

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at 1-800-232-4404 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help you are:

State Health Insurance Assistance Program (SHIP)

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

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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. GA SHIP can be reached at 1-866-552-4464 (select option 4 when prompted).

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 [Medicare.gov](https://www.medicare.gov).

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

Go to **Section 10, How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

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

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

Asking for coverage decisions before you get services

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

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

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide whether 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 will 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.

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

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

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

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

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

- **Call Member Services at 1-800-232-4404 (TTY users call 711)**
- **Get free help** from your State Health Insurance Assistance Program
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at 1-800-232-4404 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at [CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) or on our website at kp.org.)
 - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
 - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
 - If you want a friend, relative, or other person to be your representative, call Member Services at 1-800-232-4404 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at [CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) or on our website at kp.org.) This form gives that person permission to act on your behalf. It

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must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.

- We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

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

- **Section 5:** Medical care: How to ask for a coverage decision or make an appeal
- **Section 6:** Part D drugs: How to ask for a coverage decision or make an appeal
- **Section 7:** How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 8:** How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Member Services at 1-800-232-4404 (TTY users call 711). You can also get help or information from your SHIP.

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

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

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

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

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You're told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 7 and 8. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:

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

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

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

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

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

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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 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 10 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

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

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- **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 10 for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

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

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

Section 5.3 How to make a Level 1 appeal**Legal Terms:**

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

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

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

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

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

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

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this

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deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.

- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We're allowed to charge a fee for copying and sending this information to you.

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

- When our plan is reviewing your appeal, we take a careful look at all the information. We check to see if we followed all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

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

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we receive your appeal. We'll give you our decision sooner if your health condition requires us to.

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- If you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 10 of this chapter for information on complaints.)
- If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Section 5.4 The Level 2 appeal process**Legal Term:**

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

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

Step 1: The independent review organization reviews your appeal.

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

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

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

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

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

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

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

- **If the independent review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage within **72 hours** or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we get the decision from the independent review organization.
- **If this organization says no to part or all of your appeal**, it means it agrees with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:

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- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
- Tells you how to file a Level 3 appeal.

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 explains the Level 3, 4, and 5 appeals processes.

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

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

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

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

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

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

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

SECTION 6 Part D drugs: How to ask for a coverage decision or make an appeal

Section 6.1 What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term Drug List instead of *List of Covered Drugs* or *2027 Comprehensive Formulary*.

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

Part D coverage decisions and appeals**Legal Term:**

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

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

- Asking to cover a Part D drug that's not on our *2027 Comprehensive Formulary*. **Ask for an exception. Section 6.2**

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- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

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

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

Section 6.2 Asking for an exception**Legal Terms:**

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

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

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

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

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

1. **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to drugs in Tier 5 for specialty tier drugs or Tier 2 for generic drugs. You can't ask for an exception to the cost-sharing amount we require you to pay for the drug when we agree to cover a drug not on the Drug list.
2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost-sharing amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you pay as your share of the cost of the drug.

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- If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
- If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
- If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
- If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You can't ask us to change the cost-sharing tier for any drug in Tier 5 (specialty-tier drugs).
- If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions**Your doctor must tell us the medical reasons**

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

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

We can say yes or no to your request

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

Section 6.4 How to ask for a coverage decision, including an exception

Legal term:

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

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

Standard coverage decisions are made within **72 hours** after we get your request. **Fast coverage decisions** are made within **24 hours** after we get your request.

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

- You must be asking for a drug you didn't get yet. (You can't ask for a fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
 - Explains that we'll use the standard deadlines.
 - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
 - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt.

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

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

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

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

Step 3: We consider your request and give you our answer.***Deadlines for a fast coverage decision***

- We must generally give you our answer **within 24 hours** after we get your request.
 - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
 - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
 - **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
 - **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

- We must generally give you our answer **within 72 hours** after we get your request.
 - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
 - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it'll be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the 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

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- We must give you our answer **within 14 calendar days** after we get your request.
 - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
 - **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within 14 calendar days after we get your request.
 - **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

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

Section 6.5 How to make a Level 1 appeal**Legal Terms:**

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

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

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

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

- If you're appealing a decision, we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4 of this chapter.

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

- **For standard appeals, submit a written request.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at (1-800-232-4404).** Chapter 2 has contact information.

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- **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](https://www.kp.org). Include your name, contact information, and information about your claim to help us process your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We're allowed to charge a fee for copying and sending this information to you.

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
 - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

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

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.

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- 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. We'll let you know in writing if your request has been sent to the independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

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

- We must give you our answer **within 14 calendar days** after we get your request.
 - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
 - **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within **30 calendar days** after we get your request.
 - **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

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

Section 6.6 How to make a Level 2 appeal**Legal Term:**

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

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

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

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

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

Step 2: The independent review organization reviews your appeal.

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

Deadlines for fast appeal

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

Deadlines for standard appeal

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

Step 3: The independent review organization gives you its answer.***For fast appeals:***

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

For standard appeals:

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

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

If this organization says no to **part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It's also called **turning down your appeal**.) In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the appeals process.

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go on to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

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

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

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

Section 7.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at 1-800-232-4404 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

1. Read this notice carefully and ask questions if you don't understand it. It tells you:

- Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about the quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so 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.

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- 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 1-800-232-4404 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at [CMS.gov/Medicare/forms-notice/beneficiary-notice-initiative/ffs-ma-im](https://www.cms.gov/Medicare/forms-notice/beneficiary-notice-initiative/ffs-ma-im).

Section 7.2 How to make a Level 1 appeal to change your hospital discharge date

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

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-800-232-4404 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. GA SHIP can be reached at 1-866-552-4464 (select option 4 when prompted).

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

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
 - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
 - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at 1-800-232-4404 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.) Or you can get a sample notice online at [CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im](https://www.cms.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im).

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

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

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

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

What happens if the answer is no?

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

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

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

Section 7.3 How to make a Level 2 appeal to change your hospital discharge date

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

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

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

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

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

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

If the independent review organization says yes:

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

If the independent review organization says no:

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

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

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

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

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

Section 8.1 We'll tell you in advance when your coverage will be ending**Legal Term:**

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

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

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

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

Section 8.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at 1-800-232-4404 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. GA SHIP can be reached at 1-866-552-4464 (select option 4 when prompted).

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

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

How can you contact this organization?

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

Act quickly:

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

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

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

What happens during this review?

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

Step 3: Within one full day after they have all the information they need; the reviewers will tell you their decision.***What happens if the reviewers say yes?***

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

What happens if the reviewers say no?

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

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

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

Section 8.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

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

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

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

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

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

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.***What happens if the independent review organization says yes?***

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

What happens if the independent review organization says no?

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

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

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Levels 3, 4, and 5

Section 9.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

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

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

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

Level 3 appeal

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

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
 - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.

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- If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
 - If you decide to accept the decision that turns down your appeal, the appeals process is over.
 - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

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

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

Level 5 appeal

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

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

Section 9.2 Appeal Levels 3, 4, and 5 for Part D Drug Requests

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

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

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

Level 3 appeal

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

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

Level 4 appeal

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

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the answer is no, the appeals process *may or may not be over*.**
 - If you decide to accept the decision that turns down your appeal, the appeals process is over.
 - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to

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

go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal

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

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

Making complaints

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

Section 10.1 What kinds of problems are handled by the complaint process?

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan? ◦ 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?

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

Complaint	Example
Timeliness (These types of complaints are all about the <i>timeliness</i> 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 <i>fast coverage decision</i> or a <i>fast appeal</i>, 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 10.2 How to make a complaint**Legal Terms:**

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

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

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

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

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

- **Calling Member Services at 1-800-232-4404 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing. We'll also respond in writing when you make a complaint by phone if you request a written response or your complaint is related to quality of care
- **If you have a complaint, we will try to resolve your complaint over the phone.** If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. Your grievance must explain your concern, such as why you are dissatisfied with the services you received. Please see Chapter 2 for whom you should contact if you have a complaint.

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

- You must submit your grievance to us (orally or in writing) within 60 calendar days of the event or incident. We must address your grievance as quickly as your health requires, but no later than 30 calendar days after receiving your complaint. We may extend the time frame to make our decision by up to 14 calendar days if you ask for an extension, or if we justify a need for additional information and the delay is in your best interest.
- You can file a fast grievance about our decision not to expedite a coverage decision or appeal for medical care or items, or if we extend the time we need to make a decision about a coverage decision or appeal for medical care or items. We must respond to your fast grievance **within 24 hours**.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

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

Section 10.3 You can also make complaints about quality of care to the Quality Improvement Organization

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

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

Or

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

Section 10.4 You can also tell Medicare about your complaint

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

CHAPTER 10:

Ending membership in our plan

SECTION 1 Ending your membership in our plan

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

- You might leave our plan because you decide you want to leave. 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 can end your membership during the Open Enrollment Period

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

- **The Open Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of coverage:
 - Another Medicare health plan, with or without drug coverage,
 - Original Medicare *with* a separate Medicare drug plan, or
 - Original Medicare *without* a separate Medicare drug plan.
 - If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Note: If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may 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 starts on January 1.

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

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

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and 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 2.3 In certain situations, you can end your membership during a Special Enrollment Period

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

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply. These are just examples. For the full list you can contact our plan, call Medicare, or visit [Medicare.gov](https://www.medicare.gov).

- Usually, when you move
- If you have Medicaid
- If you're eligible for Extra Help paying for 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 not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

Enrollment time periods vary depending on your situation.

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

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

Note: If you disenroll from Medicare drug coverage and go without creditable prescription 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 usually end** on the first day of the month after we get your request to change your plan.
- **If you get Extra Help from Medicare to pay your drugs coverage costs:** 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.

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

If you have questions about ending your membership you can:

- **Call Member Services at 1-800-232-4404 (TTY users call 711)**
- Find the information in the ***Medicare & You 2027*** 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.

To switch from our plan to:	Here's what to do:
Original Medicare <i>with</i> 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 <i>without</i> a separate Medicare drug plan	• Send us a written request to disenroll. Call Member Services at 1-800-232-4404 (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.

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

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

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

SECTION 5 We must end your plan membership in certain situations

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

- If you no longer have Medicare Part A and Part B
- If you move out of our service area
- If you're away from our service area for more than 6 months

Chapter 10 Ending membership in our plan

- If you move or take a long trip, call Member Services at 1-800-232-4404 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area
- If you've been a member of our plan continuously before January 1999 and you were living outside of our service area before January 1999, you're still eligible as long as you haven't moved since before January 1999. However, if you move to another location outside our service area, you'll be disenrolled from our plan.
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or national, or an eligible noncitizen
- If you lie or withhold information about other insurance, you have that provides prescription drug coverage
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you'll lose drug coverage.

If you have questions or want more information on when we can end your membership, call Member Services at 1-800-232-4404 (TTY users call 711).

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

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

What should you do if this happens?

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

Chapter 10 Ending membership in our plan

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 [HHS.gov/ocr/index.html](https://www.hhs.gov/ocr/index.html).

If you have a disability and need help with access to care, call us at Member Services 1-800-232-4404 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

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

SECTION 4 Administration of this *Evidence of Coverage*

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

SECTION 5 Applications and statements

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

SECTION 6 Assignment

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

SECTION 7 Attorney and advocate fees and expenses

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

SECTION 8 Coordination of benefits

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

If your other coverage is the primary payer, it will often settle its share of payment directly with us, and you will not have to be involved. However, if payment owed to us by a primary payer is sent directly to you, you are required by Medicare law to give this primary payment to us. For more information about primary payments in third party liability situations, see Section 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
Nine Piedmont Center
Patient Business Office
3495 Piedmont Road, NE
Atlanta, Georgia 30305-1736

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the

third party's liability insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent.

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

SECTION 17 U.S. Department of Veterans Affairs

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

SECTION 18 Workers' compensation or employer's liability benefits

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

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

SECTION 19 Surrogacy

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

CHAPTER 12:

Definitions

Advantage Plus – (Optional Supplemental Benefits) – Non-Medicare-covered benefits that can be purchased for an additional premium and aren't included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits in order to get them. **This supplemental benefits package includes comprehensive dental and hearing aid** benefits for an additional monthly premium that's added to your Senior Advantage plan premium (see Chapter 1, Section 4.3, for more information).

Allowance – A specified credit amount that you can use toward the cost of an item or service. If the cost of the item(s) or service(s) you select exceeds the allowance, you will pay the amount in excess of the allowance, which doesn't 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.

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

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

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

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

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other

drugs and can't be copied exactly, so alternative forms are called biosimilars (go to "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (go to "**Interchangeable Biosimilar**").

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent \$2,400 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.

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

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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. (This is in addition to our plan’s monthly premium.) Cost-sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services or drugs are covered; 2) any fixed copayment amount that a plan requires when a specific service or drug is gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is gotten. **Note:** In some cases, you may not pay all applicable cost-sharing at the time you receive the services, and we will send you a bill later for the cost-sharing. For example, if you receive non-preventive care during a scheduled preventive care visit, we may bill you later for the cost-sharing applicable to the non-preventive care. For items ordered in advance, you pay the cost-sharing in effect on the order date (although we won’t 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 *2027 Comprehensive Formulary* is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you’re required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn’t covered under our plan, that isn’t a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all the prescription drugs covered by our plan.

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

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

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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 Medicare costs, depending on the state and the person's eligibility.

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

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

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

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

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

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

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

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction (a formulary exception).

Excluded Drug – A drug that's not a covered Part D drug, as defined under 42 U.S.C. Section 1395w-102(e).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that's approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

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

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

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Medical Benefits Chart in Chapter 4, Section 2. We cover home health care in accord with Medicare guidelines. Home health care can include services from a home health aide if the

services are part of the home health plan of care for your illness or injury. They aren't covered unless you're also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

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

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

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people won't pay a higher premium.

Initial Coverage Stage – This is the stage after you pay your deductible (if you have one) and before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

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

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

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

Kaiser Foundation Health Plan (Health Plan) – Kaiser Foundation Health Plan of Georgia, Inc., is a nonprofit corporation and a Medicare Advantage organization. This *Evidence of Coverage* sometimes refers to Health Plan as "we" or "us."

Kaiser Permanente – Health Plan and Medical Group.

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

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

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

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

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

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

Medical Care or Services – Health care services or items. Some examples of health care items include durable medical equipment, eyeglasses, and drugs covered by Medicare Part A or Part B, but not drugs covered under Medicare Part D.

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

Medically Accepted Indication – A use of a drug that is either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

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

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

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

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

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

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

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

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

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

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

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

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

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

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

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

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

Original 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.

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Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

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

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

Out-of-Pocket Threshold – The maximum amount you pay out-of-pocket for Part D drugs.

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

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that's expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan.

Plan – Kaiser Permanente Senior Advantage.

Plan Charges – Plan Charges means the following:

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

- For all other services, the payments that Kaiser Permanente makes for the services or, if Kaiser Permanente subtracts cost-sharing from its payment, the amount Kaiser Permanente would have paid if it did not subtract cost-sharing.

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

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

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

Preventive services – Health care services that help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health.

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

Prior Authorization – Approval in advance to get services and/or certain drugs based on specific criteria. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. 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 Georgia Region’s service area includes the area described in Chapter 1, Section 2.2 and network provider locations in the Western Atlanta Metro counties in Georgia. For the purposes of premiums, cost-sharing, enrollment, and disenrollment, there are multiple Senior Advantage 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 Enrollment Period – A set time when members can change their health or drug plan or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you’re getting Extra Help with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

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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.



Kaiser Permanente Senior Advantage Member Services

Method	Member Services—Contact Information
Call	1-800-232-4404 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services 1-800-232-4404 (TTY users call 711) also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
Write	Kaiser Permanente Member Services Nine Piedmont Center 3495 Piedmont Road, NE Atlanta, GA 30305-1736
Website	kp.org

State Health Insurance Assistance Program

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

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