KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern California Region

A nonprofit corporation and a Medicare Advantage Organization

EOC #7 - Kaiser Permanente Senior Advantage (HMO) with Part D
Evidence of Coverage for
SISC-SELF INSURED SCHOOLS OF CALIFORNIA - NCR

Group ID: 606321 Contract: 1 Version: 5 *EOC* Number: 7

October 1, 2021, through September 30, 2022

Member Service Contact Center
Seven days a week, 8 a.m.–8 p.m.
1-800-443-0815 (TTY users call **711**)
kp.org

This document is available for free in Spanish. Please contact our Member Service Contact Center number at **1-800-443-0815** for additional information. (TTY users should call **711**.) Hours are 8 a.m. to 8 p.m., seven days a week.

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Benefit Highlights

Accumulation Period	
The Accumulation Period for this plan is 1/1/21 through 12/31/21 (calendar year).	
Plan Out-of-Pocket Maximum	
For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to the following amount:	
For any one Member	$1,500 per calendar year
Plan Deductible	None
Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$10 per visit
Most Physician Specialist Visits	$10 per visit
Annual Wellness visit and the "Welcome to Medicare" preventive visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	$10 per visit
Urgent care consultations, evaluations, and treatment	$10 per visit
Physical, occupational, and speech therapy	$10 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$10 per procedure
Allergy injections (including allergy serum)	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	$10 per visit
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit
Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share).	
Ambulance and Transportation Services	**You Pay**
Ambulance Services	$50 per trip
Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items	$10 for up to a 100-day supply
Most brand-name items	$20 for up to a 100-day supply
Durable Medical Equipment (DME)	**You Pay**
Covered durable medical equipment for home use as described in this *EOC*	No charge
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	$10 per visit
Group outpatient mental health treatment	$5 per visit
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	$10 per visit
Group outpatient substance use disorder treatment	$5 per visit

Home Health Services	You Pay
Home health care (part-time, intermittent)	No charge

Other	You Pay
Eyeglasses or contact lenses every 24 months	Amount in excess of $150 Allowance
Hearing aid(s) every 36 months	Amount in excess of $500 Allowance per aid
Skilled Nursing Facility care (up to 100 days per benefit period)	No charge
External prosthetic and orthotic devices as described in this *EOC*	20 percent Coinsurance
Ostomy, urological, and wound care supplies	20 percent Coinsurance
Meals delivered to your home following discharge from a hospital due to congestive heart failure	No charge up to two meals per day in a consecutive four-week period, once per calendar year

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the “Benefits and Your Cost Share” and “Exclusions, Limitations, Coordination of Benefits, and Reductions” sections.

Introduction

Kaiser Foundation Health Plan, Inc. (Health Plan) has a contract with the Centers for Medicare & Medicaid Services as a Medicare Advantage Organization.

This contract provides Medicare Services (including Medicare Part D prescription drug coverage) through "Kaiser Permanente Senior Advantage (HMO) with Part D" (Senior Advantage), except for hospice care for Members with Medicare Part A, which is covered under Original Medicare. Enrollment in this Senior Advantage plan means that you are automatically enrolled in Medicare Part D. Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

This *Evidence of Coverage* ("*EOC*") describes our Senior Advantage health care coverage provided under the *Group Agreement (Agreement)* between Health Plan (Kaiser Foundation Health Plan, Inc.) and your Group (the entity with which Health Plan has entered into the *Agreement*). The *Agreement* contains additional terms such as Premiums, when coverage can change, the effective date of coverage, and the effective date of termination. The *Agreement* must be consulted to determine the exact terms of coverage. A copy of the *Agreement* is available from your Group.

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

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

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

About Kaiser Permanente

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

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

We provide covered Services to Members using Plan Providers located in our Service Area, which is described in the "Definitions" section. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Certain care when you visit the service area of another Region as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Your Cost Share" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Your Cost Share" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section
- Routine Services associated with Medicare-approved clinical trials as described under "Services Associated with Clinical Trials" in the "Benefits and Your Cost Share" section

Term of this *EOC*

This *EOC* is for the period October 1, 2021, through September 30, 2022, unless amended. Benefits, Copayments, and Coinsurance may change on January 1 of each year and at other times in accord with your Group's *Agreement* with us. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has been amended.

Definitions

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

Accumulation Period: A period of time no greater than 12 consecutive months for purposes of accumulating amounts toward any deductibles (if applicable) and out-of-pocket maximums. The Accumulation Period for this *EOC* is from 1/1/21 through 12/31/21.

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

Catastrophic Coverage Stage: The stage in the Part D Drug Benefit where you pay a low Copayment or Coinsurance for your Part D drugs after you or other qualified parties on your behalf have spent $6,550 in covered Part D drugs during the covered year. Note: This amount may change every January 1 in accord with Medicare requirements.

Centers for Medicare & Medicaid Services (CMS): The federal agency that administers the Medicare program.

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

Charges: "Charges" means the following:

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

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

Complaint: The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance."

Comprehensive Formulary (Formulary or "Drug List"): A list of Medicare Part D prescription drugs covered by our plan. The drugs on this list are selected by us with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Comprehensive Outpatient Rehabilitation Facility (CORF): A facility that mainly provides rehabilitation Services after an illness or injury, and provides a variety of Services, including physician's Services, physical therapy, social or psychological Services, and outpatient rehabilitation.

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

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

Coverage Determination: An initial determination we make about whether a Part D drug prescribed for you is covered under Part D and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription for a Part D drug to a Plan Pharmacy and the pharmacy tells you the prescription isn't covered by us, that isn't a Coverage Determination. You need to call or write us to ask for a formal decision about the coverage. Coverage Determinations are called "coverage decisions" in this *EOC*.

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

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

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

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

A mental health condition is an emergency medical condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to themselves or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

Emergency Services: Covered Services that are (1) rendered by a provider qualified to furnish Emergency Services; and (2) needed to treat, evaluate, or Stabilize an Emergency Medical Condition such as:

- A medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post Stabilization Care and not Emergency Services)

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

Extra Help: A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Family: A Subscriber and all of their Dependents.

Grievance: A type of complaint you make about us, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

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

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. This *EOC* sometimes refers to Health Plan as "we" or "us."

Home Region: The Region where you enrolled (either the Northern California Region or the Southern California Region).

Initial Enrollment Period: When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, 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.

Income Related Monthly Adjustment Amount (IRMAA): If your modified adjusted gross income as reported on your IRS tax return from two years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

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

Medical Group: The Permanente Medical Group, Inc., a for-profit professional corporation.

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). A person enrolled in a Medicare Part D plan has Medicare

Part D by virtue of his or her enrollment in the Part D plan (this *EOC* is for a Part D plan).

Medicare Advantage Organization: A public or private entity organized and licensed by a state as a risk-bearing entity that has a contract with the Centers for Medicare & Medicaid Services to provide Services covered by Medicare, except for hospice care covered by Original Medicare. Kaiser Foundation Health Plan, Inc., is a Medicare Advantage Organization.

Medicare Advantage Plan: Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. Medicare Advantage Plans may also offer Medicare Part D (prescription drug coverage). This *EOC* is for a Medicare Part D plan.

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

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

Member: A person who is eligible and enrolled under this *EOC*, and for whom we have received applicable Premiums. This *EOC* sometimes refers to a Member as "you."

Non-Physician Specialist Visits: Consultations, evaluations, and treatment by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

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

Non–Plan Pharmacy: A pharmacy other than a Plan Pharmacy. These pharmacies are also called "out-of-network pharmacies."

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

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

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

Non–Plan Skilled Nursing Facility: A Skilled Nursing Facility other than a Plan Skilled Nursing Facility.

Organization Determination: An initial determination we make about whether we will cover or pay for Services that you believe you should receive. We also make an Organization Determination when we provide you with Services, or refer you to a Non–Plan Provider for Services. Organization Determinations are called "coverage decisions" in this *EOC.*

Original Medicare ("Traditional Medicare" or "Fee-for-Service Medicare"): The Original Medicare plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay a deductible. Medicare pays its share of the Medicare approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance), and is available everywhere in the United States and its territories.

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your health resulting from an unforeseen illness or an unforeseen injury if all of the following are true:

- You are temporarily outside our Service Area
- A reasonable person would have believed that your health would seriously deteriorate if you delayed treatment until you returned to our Service Area

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

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

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

Plan Hospital: Any hospital listed in the Provider Directory on our website at **kp.org/facilities**. In the

directory, some Plan Hospitals are listed as Kaiser Permanente Medical Centers. The directory is updated periodically. The availability of Plan Hospitals may change. If you have questions, please call our Member Service Contact Center.

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

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

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Out-of-Pocket Maximum: The total amount of Cost Share you must pay under this *EOC* in the calendar year for certain covered Services that you receive in the same calendar year. Please refer to the "Benefits and Your Cost Share" section to find your Plan Out-of-Pocket Maximum amount and to learn which Services apply to the Plan Out-of-Pocket Maximum.

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

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

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

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

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that this condition is Stabilized.

Premiums: The periodic amounts that your Group is responsible for paying for your membership under this *EOC*.

Preventive Services: Covered Services that prevent or detect illness and do one or more of the following:

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

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

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

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

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

Serious Emotional Disturbance of a Child Under Age 18: A condition identified as a "mental disorder" in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age

according to expected developmental norms, if the child also meets at least one of the following three criteria:

- As a result of the mental disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
- The child displays psychotic features, or risk of suicide or violence due to a mental disorder
- The child meets special education eligibility requirements under Section 5600.3(a)(2)(C) of the Welfare and Institutions Code

Service Area: The geographic area approved by the Centers for Medicare & Medicaid Services within which an eligible person may enroll in Senior Advantage. Note: Subject to approval by the Centers for Medicare & Medicaid Services, we may reduce or expand our Service Area effective any January 1. ZIP codes are subject to change by the U.S. Postal Service. The ZIP codes below for each county are in our Service Area:

- All ZIP codes in Alameda County are inside our Service Area: 94501–02, 94505, 94514, 94536–46, 94550–52, 94555, 94557, 94560, 94566, 94568, 94577–80, 94586–88, 94601–15, 94617–21, 94622–24, 94649, 94659–62, 94666, 94701–10, 94712, 94720, 95377, 95391
- The following ZIP codes in Amador County are inside our Service Area: 95640, 95669
- All ZIP codes in Contra Costa County are inside our Service Area: 94505–07, 94509, 94511, 94513–14, 94516–31, 94547–49, 94551, 94553, 94556, 94561, 94563–65, 94569–70, 94572, 94575, 94582–83, 94595–98, 94706–08, 94801–08, 94820, 94850
- The following ZIP codes in El Dorado County are inside our Service Area: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762
- The following ZIP codes in Fresno County are inside our Service Area: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–30, 93737, 93740–41, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–79, 93786, 93790–94, 93844, 93888
- The following ZIP codes in Kings County are inside our Service Area: 93230, 93232, 93242, 93631, 93656
- The following ZIP codes in Madera County are inside our Service Area: 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720
- All ZIP codes in Marin County are inside our Service Area: 94901, 94903–04, 94912–15, 94920, 94924–25, 94929–30, 94933, 94937–42, 94945–50, 94956–57, 94960, 94963–66, 94970–71, 94973–74, 94976–79
- The following ZIP codes in Mariposa County are inside our Service Area: 93601, 93623, 93653
- All ZIP codes in Napa County are inside our Service Area: 94503, 94508, 94515, 94558–59, 94562, 94567, 94573–74, 94576, 94581, 94599, 95476
- The following ZIP codes in Placer County are inside our Service Area: 95602–04, 95610, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95703, 95722, 95736, 95746–47, 95765
- All ZIP codes in Sacramento County are inside our Service Area: 94203–09, 94211, 94229–30, 94232, 94234–37, 94239–40, 94244, 94247–50, 94252, 94254, 94256–59, 94261–63, 94267–69, 94271, 94273–74, 94277–80, 94282–85, 94287–91, 94293–98, 94571, 95608–11, 95615, 95621, 95624, 95626, 95628, 95630, 95632, 95638–39, 95641, 95652, 95655, 95660, 95662, 95670–71, 95673, 95678, 95680, 95683, 95690, 95693, 95741–42, 95757–59, 95763, 95811–38, 95840–43, 95851–53, 95860, 95864–67, 95894, 95899
- All ZIP codes in San Francisco County are inside our Service Area: 94102–05, 94107–12, 94114–27, 94129–34, 94137, 94139–47, 94151, 94158–61, 94163–64, 94172, 94177, 94188
- All ZIP codes in San Joaquin County are inside our Service Area: 94514, 95201–15, 95219–20, 95227, 95230–31, 95234, 95236–37, 95240–42, 95253, 95258, 95267, 95269, 95296–97, 95304, 95320, 95330, 95336–37, 95361, 95366, 95376–78, 95385, 95391, 95632, 95686, 95690
- All ZIP codes in San Mateo County are inside our Service Area: 94002, 94005, 94010–11, 94014–21, 94025–28, 94030, 94037–38, 94044, 94060–66, 94070, 94074, 94080, 94083, 94128, 94303, 94401–04, 94497
- The following ZIP codes in Santa Clara County are inside our Service Area: 94022–24, 94035, 94039–43, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–

36, 95138–41, 95148, 95150–61, 95164, 95170, 95172–73, 95190–94, 95196

- All ZIP codes in Santa Cruz County are inside our Service Area: 95001, 95003, 95005–07, 95010, 95017–19, 95033, 95041, 95060–67, 95073, 95076–77
- All ZIP codes in Solano County are inside our Service Area: 94503, 94510, 94512, 94533–35, 94571, 94585, 94589–92, 95616, 95618, 95620, 95625, 95687–88, 95690, 95694, 95696
- The following ZIP codes in Sonoma County are inside our Service Area: 94515, 94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, 95492
- All ZIP codes in Stanislaus County are inside our Service Area: 95230, 95304, 95307, 95313, 95316, 95319, 95322–23, 95326, 95328–29, 95350–58, 95360–61, 95363, 95367–68, 95380–82, 95385–87, 95397
- The following ZIP codes in Sutter County are inside our Service Area: 95626, 95645, 95659, 95668, 95674, 95676, 95692, 95836–37
- The following ZIP codes in Tulare County are inside our Service Area: 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
- The following ZIP codes in Yolo County are inside our Service Area: 95605, 95607, 95612, 95615–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99
- The following ZIP codes in Yuba County are inside our Service Area: 95692, 95903, 95961

For each ZIP code listed for a county, our Service Area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside our Service Area unless that other county is listed above and that ZIP code is also listed for that other county. If you have a question about whether a ZIP code is in our Service Area, please call our Member Service Contact Center. Also, the ZIP codes listed above may include ZIP codes for Post Office boxes and commercial rental mailboxes. A Post Office box or rental mailbox cannot be used to determine whether you meet the residence eligibility requirements for Senior Advantage. Your permanent residence address must be used to determine your Senior Advantage eligibility.

Services: Health care services or items ("health care" includes both physical health care and mental health care), behavioral health treatment covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the "Benefits" section, and services to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness.

Severe Mental Illness: The following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa.

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

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

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

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

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

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

Premiums, Eligibility, and Enrollment

Premiums

Your Group is responsible for paying Premiums. If you are responsible for any contribution to the Premiums that your Group pays, your Group will tell you the amount, when Premiums are effective, and how to pay your Group. In addition to any amount you must pay your Group, you must also continue to pay Medicare your monthly Medicare premium.

If you do not have Medicare Part A, you may be eligible to purchase Medicare Part A from Social Security. Please contact Social Security for more information. If you get Medicare Part A, this may reduce the amount you would be expected to pay to your Group, please check with your Group's benefits administrator.

Medicare Premiums

Medicare Part D premium due to income

If your modified adjusted gross income as reported on your IRS tax return from two years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. 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 will get a bill from Medicare. The extra amount must be paid separately and cannot be paid with your monthly plan premium.

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact the Social Security Office at **1-800-772-1213** (TTY users call **1-800-325-0778**), 7 a.m. to 7 p.m., Monday through Friday.

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will be disenrolled from Kaiser Permanente Senior Advantage and lose Part D prescription drug coverage.

Medicare Part D late enrollment penalty

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a Part D late enrollment penalty if at any time after your Initial Enrollment Period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your Initial Enrollment Period or how many full calendar months you went without creditable prescription drug coverage (this *EOC* is for a Part D plan). You will have to pay this penalty for as long as you have Part D coverage. Your Group will inform you if the penalty applies to you.

If you disagree with your Part D late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Call our Member Service Contact Center at the number on the front of this booklet to find out more about how to do this.

Note: If you receive Extra Help from Medicare to pay for your Part D prescription drugs, you will not pay a late enrollment penalty.

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, and prescription Copayments. This "Extra Help" also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for "Extra Help." Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

You may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week;
- The Social Security Office at **1-800-772-1213** (TTY users call **1-800-325-0778**), 7 a.m. to 7 p.m., Monday through Friday (applications); or
- Your state Medicaid office (applications). See the "Important Phone Numbers and Resources" section for contact information

If you qualify for "Extra Help," we will send you an *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*), that explains your costs as a Member of our plan. If the amount of your "Extra Help" changes during the year, we will also mail you an updated *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*.

Who Is Eligible

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

Group eligibility requirements

You must meet your Group's eligibility requirements. Your Group is required to inform Subscribers of its eligibility requirements.

Senior Advantage eligibility requirements

- You must have Medicare Part B
- You must be a United States citizen or lawfully present in the United States
- Your Medicare coverage must be primary and your Group's health care plan must be secondary
- You may not be enrolled in another Medicare Health Plan or Medicare prescription drug plan

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

Service Area eligibility requirements

You must live in our Service Area, unless you have been continuously enrolled in Senior Advantage since December 31, 1998, and lived outside our Service Area during that entire time. In which case, you may continue your membership unless you move and are still outside our Service Area. The "Definitions" section describes our Service Area and how it may change.

Moving outside our Service Area. If you permanently move outside our Service Area, or you are temporarily absent from our Service Area for a period of more than six months in a row, you must notify us and you cannot continue your Senior Advantage membership under this *EOC*.

Send your notice to:

Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 232400
San Diego, CA 92193

It is in your best interest to notify us as soon as possible because until your Senior Advantage coverage is officially terminated by the Centers for Medicare & Medicaid Services, you will not be covered by us or Original Medicare for any care you receive from Non–Plan Providers, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Certain care when you visit the service area of another Region as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Your Cost Share" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Your Cost Share" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section
- Routine Services associated with Medicare-approved clinical trials as described under "Services Associated with Clinical Trials" in the "Benefits and Your Cost Share" section

If you are not eligible to continue enrollment because you move to the service area of another Region, please contact your Group to learn about your Group health care options. You may be able to enroll in the service area of another Region if there is an agreement between your Group and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*.

For more information about the service areas of the other Regions, please call our Member Service Contact Center.

Eligibility as a Subscriber

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

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

Eligibility as a Dependent

Dependent eligibility is subject to your Group's eligibility requirements, which are not described in this *EOC*. You can obtain your Group's eligibility requirements directly from your Group. If you are a Subscriber enrolled under this *EOC* or a subscriber enrolled in a non-Medicare plan offered by your Group, the following persons may be eligible to enroll as your Dependents under this *EOC* if they meet all of the other requirements described under "Group eligibility requirements," "Senior Advantage eligibility requirements," and "Service Area eligibility requirements" in this "Who Is Eligible" section:

- Your Spouse
- Your or your Spouse's Dependent children, who are under age 26, if they are any of the following:
  - sons, daughters, or stepchildren
  - adopted children
  - children placed with you for adoption, but not including children placed with you for foster care
  - children for whom you or your Spouse is the court-appointed guardian (or was when the child reached age 18)
- Dependent children of the Subscriber or Spouse (including adopted children and children placed with you for adoption, but not including children placed with you for foster care) who reach the age limit may continue coverage under this *EOC* if all of the following conditions are met:
  - they meet all requirements to be a Dependent except for the age limit
  - your Group permits enrollment of Dependents
  - they are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred before they reached the age limit for Dependents
  - they receive 50 percent or more of their support and maintenance from you or your Spouse
  - you give us proof of their incapacity and dependency within 60 days after we request it (see "Disabled Dependent certification" below in this "Eligibility as a Dependent" section)
- Certain Dependents may continue their memberships for a limited time after membership would otherwise terminate as a result of the Subscriber's death if permitted by your Group (please ask your Group for details)

Disabled Dependent certification. One of the requirements for a Dependent to be eligible to continue coverage as a disabled Dependent is that the Subscriber must provide us documentation of the dependent's incapacity and dependency as follows:

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

- If the child is not a Member because you are changing coverage, you must give us proof, within 60 days after we request it, of the child's incapacity and dependency as well as proof of the child's coverage under your prior coverage. In the future, you must provide proof of the child's continued incapacity and dependency within 60 days after you receive our request, but not more frequently than annually

Dependents not eligible to enroll under a Senior Advantage plan. If you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this *EOC*, you may be able to enroll them as your dependents under a non-Medicare plan offered by your Group. Please contact your Group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

How to Enroll and When Coverage Begins

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

- Your Group may have additional requirements, which allow enrollment in other situations
- The effective date of your Senior Advantage coverage under this *EOC* must be confirmed by the Centers for Medicare & Medicaid Services, as described under "Effective date of Senior Advantage coverage" in this "How to Enroll and When Coverage Begins" section

If you are a Subscriber under this *EOC* and you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this *EOC*, you may be able to enroll them as your dependents under a non-Medicare plan offered by your Group. Please contact your Group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

If you are eligible to be a Dependent under this *EOC* but the subscriber in your family is enrolled under a non-Medicare plan offered by your Group, the subscriber must follow the rules applicable to Subscribers who are enrolling Dependents in this "How to Enroll and When Coverage Begins" section.

Effective date of Senior Advantage coverage

After we receive your completed Senior Advantage Election Form, we will submit your enrollment request to the Centers for Medicare & Medicaid Services for confirmation and send you a notice indicating the proposed effective date of your Senior Advantage coverage under this *EOC*.

If the Centers for Medicare & Medicaid Services confirms your Senior Advantage enrollment and effective date, we will send you a notice that confirms your enrollment and effective date. If the Centers for Medicare & Medicaid Services tells us that you do not have Medicare Part B coverage, we will notify you that you will be disenrolled from Senior Advantage.

New employees

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

Effective date of Senior Advantage coverage. The effective date of Senior Advantage coverage for new employees and their eligible family Dependents or newly acquired Dependents, is determined by your Group, subject to confirmation by the Centers for Medicare & Medicaid Services.

Group open enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person to your Group during your Group's open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the effective date of coverage, which is subject to confirmation by the Centers for Medicare & Medicaid Services.

Special enrollment

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

- You become eligible because you experience a qualifying event (sometimes called a "triggering event") as described in this "Special enrollment" section
- You did not enroll in any coverage offered by your Group when you were first eligible and your Group does not give us a written statement that verifies you

signed a document that explained restrictions about enrolling in the future. Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, from the Subscriber

Special enrollment due to new Dependents. You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, within 30 days after marriage, establishment of domestic partnership, birth, adoption, or placement for adoption by submitting to your Group a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person.

Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application, and a Senior Advantage Election Form for each person, from the Subscriber. Subject to confirmation by the Centers for Medicare & Medicaid Services, enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, date of adoption, or the date you or your Spouse have newly assumed a legal right to control health care in anticipation of adoption.

Special enrollment due to loss of other coverage. You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, if all of the following are true:

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

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

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

Special enrollment due to court or administrative order. Within 31 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person.

Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of coverage resulting from a court or administrative order is the first of the month following the date we receive the enrollment request, unless your Group specifies a different effective date (if your Group specifies a different effective date, the effective date cannot be earlier than the date of the order).

Special enrollment due to eligibility for premium assistance. You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, if you or a dependent become eligible for premium assistance through the Medi-Cal program. Premium assistance is when the Medi-Cal program pays all or part of premiums for employer group coverage for a Medi-Cal beneficiary. To request

enrollment in your Group's health care coverage, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, to your Group within 60 days after you or a dependent become eligible for premium assistance. Please contact the California Department of Health Care Services to find out if premium assistance is available and the eligibility requirements.

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

How to Obtain Services

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

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Services" section
- Certain care when you visit the service area of another Region as described under "Receiving Care Outside of Your Home Region" in this "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Your Cost Share" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Your Cost Share" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section
- Routine Services associated with Medicare-approved clinical trials as described under "Services Associated with Clinical Trials" in the "Benefits and Your Cost Share" section

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

Routine Care

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

Urgent Care

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

For information about Out-of-Area Urgent Care, please refer to "Urgent Care" in the "Emergency Services and Urgent Care" section.

Our Advice Nurses

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. Whether you are calling for advice or to make an appointment, you can speak to an advice nurse. They can often answer questions about a minor concern, tell you what to do if a Plan Medical Office is closed, or advise you about what to do next, including making a same-day Urgent Care appointment for you if it's medically appropriate. To reach an advice nurse, please refer to our Provider Directory or call our Member Service Contact Center.

Your Personal Plan Physician

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

We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians

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

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

Getting a Referral

Referrals to Plan Providers

A Plan Physician must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, dermatology, and physical, occupational, and speech therapies. However, you do not need a referral or prior authorization to receive most care from any of the following Plan Providers:

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

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

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

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

Standing referrals

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

Medical Group authorization procedure for certain referrals

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

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

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

For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at **kp.org/UM** or call our Member Service Contact Center to request a printed copy. Please refer to "Post-Stabilization Care" under "Emergency Services" in the "Emergency Services and Urgent Care" section for authorization requirements that apply to Post-Stabilization Care from Non–Plan Providers.

Additional information about prior authorization for durable medical equipment, ostomy, urological, and wound care supplies. The prior authorization process for durable medical equipment, ostomy, urological, and wound care supplies includes the use of formulary

guidelines. These guidelines were developed by a multidisciplinary clinical and operational work group with review and input from Plan Physicians and medical professionals with clinical expertise. The formulary guidelines are periodically updated to keep pace with changes in medical technology, Medicare guidelines, and clinical practice.

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

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

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

If the Medical Group does not authorize all of the Services requested and you want to appeal the decision, you can file a grievance as described in the "Coverage Decisions, Appeals, and Complaints" section.

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

Travel and lodging for certain referrals

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

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

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

Second Opinions

If you want a second opinion, you can ask Member Services to help you arrange one with a Plan Physician who is an appropriately qualified medical professional for your condition. If there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, Member Services will help you arrange a consultation with a Non–Plan Physician for a second opinion. For purposes of this "Second Opinions" provision, an "appropriately qualified medical professional" is a physician who is acting within their scope of practice and who possesses a clinical background, including training and expertise, related to the illness or condition associated with the request for a second medical opinion.

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

- Your Plan Physician has recommended a procedure and you are unsure about whether the procedure is reasonable or necessary
- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions

- The clinical indications are not clear or are complex and confusing
- A diagnosis is in doubt due to conflicting test results
- The Plan Physician is unable to diagnose the condition
- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have concerns about the diagnosis or plan of care
- An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial and of your right to file a grievance as described in the "Coverage Decisions, Appeals, and Complaints" section.

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

Contracts with Plan Providers

How Plan Providers are paid

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

Financial liability

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

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

Termination of a Plan Provider's contract and completion of Services

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements.

Completion of Services. If you are undergoing treatment for specific conditions from a Plan Physician (or certain other providers) when the contract with him or her ends (for reasons other than medical disciplinary cause, criminal activity, or the provider's voluntary termination), you may be eligible to continue receiving covered care from the terminated provider for your condition. The conditions that are subject to this continuation of care provision are:

- Certain conditions that are either acute, or serious and chronic. We may cover these Services for up to 90 days, or longer, if necessary for a safe transfer of care to a Plan Physician or other contracting provider as determined by the Medical Group
- A high-risk pregnancy or a pregnancy in its second or third trimester. We may cover these Services through postpartum care related to the delivery, or longer if Medically Necessary for a safe transfer of care to a Plan Physician as determined by the Medical Group

The Services must be otherwise covered under this *EOC*. Also, the terminated provider must agree in writing to our contractual terms and conditions and comply with them for Services to be covered by us.

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

More information. For more information about this provision, or to request the Services, please call our Member Service Contact Center.

Receiving Care Outside of Your Home Region

If you have questions about your coverage when you are away from home, call the Away from Home Travel line at **1-951-268-3900** 24 hours a day, seven days a week (except closed holidays). For example, call this number for the following concerns:

- What you should do to prepare for your trip
- What Services are covered when you are outside our Service Area
- How to get care in another Region
- How to request reimbursement if you paid for covered Services outside our Service Area

You can also get information on our website at **kp.org/travel**.

Receiving Care in the Service Area of another Region

If you visit the service area of another Region temporarily, you can receive certain care covered under this *EOC* from designated providers in that service area.

Please call our Member Service Contact Center or our away from home travel line at **1-951-268-3900** (TTY users call **711)**, 24 hours a day, seven days a week except holidays, for more information about getting care when visiting another Kaiser Permanente Region's service area, including coverage information and facility locations in the service area of another Region.

Your ID Card

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

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

Your Medicare card

Do NOT use your red, white, and blue Medicare card for covered medical Services while you are a Member of this plan. If you use your Medicare card instead of your Senior Advantage membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospice services or participate in routine research studies.

Getting Assistance

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

Member Services

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

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

Many Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Contact Center representatives are available to assist you seven days a week from 8 a.m. to 8 p.m. toll free at **1-800-443-0815** or **711** (TTY for the deaf, hard of hearing, or speech impaired). For your convenience, you can also contact us through our website at **kp.org**.

Cost Share estimates

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

Plan Facilities

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

At most of our Plan Facilities, you can usually receive all of the covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a

particular Plan Facility, and we encourage you to use the facility that will be most convenient for you:

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available from Plan Hospital Emergency Departments (for Emergency Department locations, refer to our Provider Directory or call our Member Service Contact Center)
- Same–day Urgent Care appointments are available at many locations (for Urgent Care locations, refer to our Provider Directory or call our Member Service Contact Center)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services Department (for locations, refer to our Provider Directory or call our Member Service Contact Center)
- Plan Pharmacies are located at most Plan Medical Offices (refer to *Kaiser Permanente Pharmacy Directory* for pharmacy locations)

Provider Directory

The *Provider Directory* lists our Plan Providers. It is subject to change and periodically updated. If you don't have our *Provider Directory*, you can get a copy by calling our Member Service Contact Center or by visiting our website at **kp.org/directory**.

Pharmacy Directory

The *Kaiser Permanente Pharmacy Directory* lists the locations of Plan Pharmacies, which are also called "network pharmacies." The pharmacy directory provides additional information about obtaining prescription drugs. It is subject to change and periodically updated. If you don't have the *Kaiser Permanente Pharmacy Directory*, you can get a copy by calling our Member Service Contact Center or by visiting our website at **kp.org/directory**.

Emergency Services and Urgent Care

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital Emergency Department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non–Plan Providers anywhere in the world.

Emergency Services are available from Plan Hospital Emergency Departments 24 hours a day, seven days a week.

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that your condition is Stabilized.

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

Be sure to ask the Non–Plan Provider to tell you what care (including any transportation) we have authorized because we will not cover unauthorized Post-Stabilization Care or related transportation provided by Non–Plan Providers. If you receive care from a Non–Plan Provider that we have not authorized, you may have to pay the full cost of that care if you are notified by the Non–Plan Provider or us about your potential liability.

Your Cost Share

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

- If you receive Emergency Services in the Emergency Department of a Non–Plan Hospital, you pay the Cost Share for an Emergency Department visit as described under "Outpatient Care"
- If we gave prior authorization for inpatient Post-Stabilization Care in a Non–Plan Hospital, you pay the Cost Share for hospital inpatient care as described under "Hospital Inpatient Care"

Urgent Care

Inside the Service Area

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

In the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC* (such as a major disaster, epidemic, war, riot, and civil insurrection), we cover Urgent Care inside our Service Area from a Non–Plan Provider.

Out-of-Area Urgent Care

If you need Urgent Care due to an unforeseen illness or unforeseen injury, we cover Medically Necessary Services to prevent serious deterioration of your health from a Non–Plan Provider if all of the following are true:

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

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

We do not cover follow-up care from Non–Plan Providers after you no longer need Urgent Care. To obtain follow-up care from a Plan Provider, call the appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call our Member Service Contact Center.

Your Cost Share

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

- If you receive an Urgent Care evaluation as part of covered Out-of-Area Urgent Care from a Non–Plan Provider, you pay the Cost Share for Urgent Care consultations, evaluations, and treatment as described under "Outpatient Care"
- If the Out-of-Area Urgent Care you receive includes an X-ray, you pay the Cost Share for an X-ray as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services" in addition to the Cost Share for the Urgent Care evaluation
- Note: If you receive Urgent Care in an Emergency Department, you pay the Cost Share for an Emergency Department visit as described under "Outpatient Care."

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Urgent Care from a Non–Plan Provider as described in this "Emergency Services and Urgent Care" section, or emergency ambulance Services described under "Ambulance Services" in the "Benefits and Your Cost Share" section, ask the Non–Plan Provider to submit a claim to us within 60 days or as soon as possible, but no later than 15 months after receiving the care (or up to 27 months according to Medicare rules, in some cases). If the provider refuses to bill us, send us the unpaid bill with a claim form. Also, if you receive Services from a Plan Provider that are prescribed by a Non–Plan Provider as part of covered Emergency Services, Post-Stabilization Care, and Urgent Care (for example, drugs), you may be required to pay for the Services and file a claim. To request payment or reimbursement, you must file a claim as described in the "Requests for Payment" section.

We will reduce any payment we make to you or the Non–Plan Provider by the applicable Cost Share. Also, in accord with applicable law, we will reduce our payment by any amounts paid or payable (or that in the absence of this plan would have been payable) for the Services under any insurance policy, or any other contract or coverage, or any government program except Medicaid.

Benefits and Your Cost Share

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

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
  - Preventive Services
  - health care items and services for diagnosis, assessment, or treatment
  - health education covered under "Health Education" in this "Benefits and Your Cost Share" section
  - other health care items and services
  - other services to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except for:
  - certain care when you visit the service area of another Region, as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section
  - drugs prescribed by dentists, as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section
  - emergency ambulance Services, as described under "Ambulance Services" in this "Benefits and Your Cost Share" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
  - eyeglasses and contact lenses prescribed by Non–Plan Providers, as described under "Vision Services" in this "Benefits and Your Cost Share" section
  - out-of-area dialysis care, as described under "Dialysis Care" in this "Benefits and Your Cost Share" section
  - routine Services associated with Medicare-approved clinical trials, as described under "Services Associated with Clinical Trials" in this "Benefits and Your Cost Share" section
- You receive the Services from Plan Providers inside our Service Area, except for:
  - authorized referrals, as described under "Getting a Referral" in the "How to Obtain Services" section
  - certain care when you visit the service area of another Region, as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section
  - emergency ambulance Services, as described under "Ambulance Services" in this "Benefits and Your Cost Share" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
  - out-of-area dialysis care, as described under "Dialysis Care" in this "Benefits and Your Cost Share" section
  - prescription drugs from Non–Plan Pharmacies, as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section
  - routine Services associated with Medicare-approved clinical trials, as described under "Services Associated with Clinical Trials" in this "Benefits and Your Cost Share" section
- The Medical Group has given prior authorization for the Services, if required, as described under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

Please also refer to:

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

Your Cost Share

Your Cost Share is the amount you are required to pay for covered Services. The Cost Share for covered Services is listed in this *EOC*. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible.

Cost Share during COVID-19 pandemic

If you live in a geographic area that is subject to a public health emergency declaration, you will not have to pay

Cost Share related to COVID-19 testing or treatment for the duration of the public health emergency.

General rules, examples, and exceptions

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

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

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

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

In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for your Cost Share (for example, some Laboratory Departments are not able to collect Cost Shares).

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

In some cases, a Non–Plan Provider may be involved in the provision of covered Services at a Plan Facility or a contracted facility where we have authorized you to

receive care. You are not responsible for any amounts beyond your Cost Share for the covered Services you receive at Plan Facilities or at contracted facilities where we have authorized you to receive care. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Requests for Payment" section.

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

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

Getting an estimate of your Cost Share

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

- If you have a Plan Deductible and would like an estimate for Services that are subject to the Plan Deductible, please call **1-800-390-3507** (TTY users call **711**) Monday through Friday, 7 a.m. to 7 p.m.
- For all other Cost Share estimates, please call **1-800-443-0815**, 8 a.m. to 8 p.m., seven days a week (TTY users should call **711**)

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

Copayments and Coinsurance

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

Note: If Charges for Services are less than the Copayment described in this *EOC*, you will pay the lesser amount.

Plan Out-of-Pocket Maximum

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

- **$1,500** per calendar year for any one Member

For Services subject to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share during the remainder of the calendar year, but every other Member in your Family must continue to pay Cost Share during the remainder of the calendar year until either he or she reaches the **$1,500** maximum for any one Member.

Payments that count toward the Plan Out-of-Pocket Maximum. Any amounts you pay for the following Services apply toward the out-of-pocket maximum:

- Covered in-network Medicare Part A and Part B Services
- Medicare Part B drugs
- Residential treatment program Services covered in the "Substance Use Disorder Treatment" and "Mental Health Services" sections

Copayments and Coinsurance you pay for Services that are not described above, do not apply to the out-of-pocket maximum. For these Services, you must pay

Copayments or Coinsurance even if you have already reached the out-of-pocket maximum. In addition:

- If your plan includes supplemental chiropractic or acupuncture Services, or fitness benefit, described in an amendment to this *EOC*, those Services do not apply toward the maximum
- If your plan includes an Allowance for specific Services (such as eyeglasses, contact lenses, or hearing aids), any amounts you pay that exceed the Allowance do not apply toward the maximum

Outpatient Care

We cover the following outpatient care subject to the Cost Share indicated:

Office visits

- Primary Care Visits and Non-Physician Specialist Visits that are not described elsewhere in this *EOC*: **a $10 Copayment per visit**
- Physician Specialist Visits that are not described elsewhere in this *EOC*: **a $10 Copayment per visit**
- Outpatient visits that are available as group appointments that are not described elsewhere in this *EOC*: **a $5 Copayment per visit**
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician: **no charge Note:** Effective January 1, 2022, the Cost Share for house calls will be as follows:
  - Primary Care Visits and Non-Physician Specialist Visits: **a $10 Copayment per visit**
  - Physician Specialist Visits: **a $10 Copayment per visit**
- Routine physical exams that are medically appropriate preventive care in accord with generally accepted professional standards of practice: **no charge**
- Family planning counseling, or internally implanted time-release contraceptives or intrauterine devices (IUDs) and office visits related to their administration and management: **a $10 Copayment per visit**
- After confirmation of pregnancy, the normal series of regularly scheduled preventive prenatal care exams and the first postpartum follow-up consultation and exam: **a $10 Copayment per visit**
- Voluntary termination of pregnancy: **a $10 Copayment per procedure**
- Physical, occupational, and speech therapy in accord with Medicare guidelines: **a $10 Copayment per visit**
- Group and individual physical therapy prescribed by a Plan Provider to prevent falls: **no charge**
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program in accord with Medicare guidelines: **a $10 Copayment per day**
- Manual manipulation of the spine to correct subluxation, in accord with Medicare guidelines, is covered when provided by a Plan Provider or a chiropractor when referred by a Plan Provider: **a $10 Copayment per visit**

Acupuncture Services

- Acupuncture for chronic low back pain up to 12 visits in 90 days, in accord with Medicare guidelines: **a $10 Copayment per visit**. Chronic low back pain is defined as follows:
  - lasting 12 weeks or longer
  - non-specific, in that it has no identifiable systemic cause (i.e. not associated with metastatic, inflammatory, infectious, etc. disease)
  - not associated with surgery or pregnancy
- An additional eight sessions are covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.
- Acupuncture not covered by Medicare (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain): **a $10 Copayment per visit**

Emergency and Urgent Care visits

- Urgent Care consultations, evaluations, and treatment: **a $10 Copayment per visit**
- Emergency Department visits: **a $50 Copayment per visit**
- **If you are admitted from the Emergency Department**. If you are admitted to the hospital as an inpatient for covered Services (either within 24 hours for the same condition or after an observation stay), then the Services you received in the Emergency Department and observation stay, if applicable, will be considered part of your inpatient hospital stay. For the Cost Share for inpatient care, please refer to "Hospital Inpatient Care" in this "Benefits and Your Cost Share" section. However, the Emergency

Department Cost Share does apply if you are admitted for observation but are not admitted as an inpatient.

Outpatient surgeries and procedures

- Outpatient surgery and outpatient procedures when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **a $10 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a $10 Copayment per procedure**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this "Benefits and Your Cost Share" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Pre- and post-operative visits:
  - Primary Care Visits and Non-Physician Specialist Visits: **a $10 Copayment per visit**
  - Physician Specialist Visits: **a $10 Copayment per visit**

Administered drugs and products

Administered drugs and products are medications and products that require administration or observation by medical personnel. We cover these items when prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility or during home visits.

We cover the following Services and their administration in a Plan Facility at the Cost Share indicated:

- Whole blood, red blood cells, plasma, and platelets: **no charge**
- Allergy antigens (including administration): **a $3 Copayment per visit**
- Cancer chemotherapy drugs and adjuncts: **no charge**
- Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products ("biologics") derived from tissue, cells, or blood: **no charge**
- Tuberculosis skin tests: **no charge**
- All other administered drugs and products: **no charge**
- We cover drugs and products administered to you during a home visit at **no charge**.

Certain administered drugs are Preventive Services. Please refer to "Preventive Services" for information on immunizations.

Note: Vaccines covered by Medicare Part D are not covered under this "Outpatient Care" section (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section).

For Services related to "Outpatient Care," refer to these sections

- Bariatric Surgery
- Dental Services for Radiation Treatment and Dental Anesthesia
- Dialysis Care
- Durable Medical Equipment ("DME") for Home Use
- Fertility Services
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Meals
- Mental Health Services
- Ostomy, Urological, and Wound Care Supplies
- Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services
- Outpatient Prescription Drugs, Supplies, and Supplements
- Preventive Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Substance Use Disorder Treatment
- Transplant Services
- Vision Services

Hospital Inpatient Care

We cover the following inpatient Services in a Plan Hospital, when the Services are generally and

customarily provided by acute care general hospitals inside our Service Area:

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

- **Your Cost Share**. We cover hospital inpatient Services at **no charge**.

For Services related to "Hospital Inpatient Care," refer to these sections

The following types of inpatient Services are covered only as described under the following headings in this "Benefits and Your Cost Share" section:

- Bariatric Surgery
- Dental Services for Radiation Treatment and Dental Anesthesia
- Dialysis Care
- Fertility Services
- Hospice Care
- Mental Health Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Religious Nonmedical Health Care Institution Services
- Services Associated with Clinical Trials
- Skilled Nursing Facility Care
- Substance Use Disorder Treatment
- Transplant Services

Ambulance Services

Emergency

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

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

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

Nonemergency

Inside our Service Area, we cover nonemergency ambulance Services in accord with Medicare guidelines if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to and from qualifying locations as defined by Medicare guidelines.

Your Cost Share

You pay the following for covered ambulance Services:

- Emergency ambulance Services: **a $50 Copayment per trip**
- Nonemergency Services: **a $50 Copayment per trip**

Ambulance Services exclusion(s)

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

Bariatric Surgery

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

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

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

For the following Services related to "Bariatric Surgery," refer to these sections

- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Dental Services for Radiation Treatment and Dental Anesthesia

Dental Services for radiation treatment

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

Dental anesthesia

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

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

We do not cover any other Services related to the dental procedure, such as the dentist's Services, unless the Service is covered in accord with Medicare guidelines.

Your Cost Share

You pay the following for dental Services covered under this "Dental Services for Radiation Treatment and Dental Anesthesia" section:

- Non-Physician Specialist Visits with dentists for Services covered under this "Dental Services for Radiation Treatment and Dental Anesthesia" section: **a $10 Copayment per visit**
- Physician Specialist Visits for Services covered under this "Dental Services for Radiation Treatment and Dental Anesthesia" section: **a $10 Copayment per visit**
- Outpatient surgery and outpatient procedures when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **a $10 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a $10 Copayment per procedure**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this "Benefits and Your Cost Share" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging,

Laboratory, and Other Diagnostic and Treatment Services")

- Hospital inpatient care (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services): **no charge**

For the following Services related to "Dental Services for Radiation Treatment and Dental Anesthesia," refer to these sections

- Office visits not described in this "Dental Services for Radiation Treatment and Dental Anesthesia" section (refer to "Outpatient Care")
- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Dialysis Care

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

- You satisfy all medical criteria developed by the Medical Group
- The facility is certified by Medicare
- A Plan Physician provides a written referral for your dialysis treatment except for out-of-area dialysis care

We also cover hemodialysis and peritoneal home dialysis (including equipment, training, and medical supplies). Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

Out-of-area dialysis care

We cover dialysis (kidney) Services that you get at a Medicare-certified dialysis facility when you are temporarily outside our Service Area. If possible, before you leave the Service Area, please let us know where you are going so we can help arrange for you to have maintenance dialysis while outside our Service Area.

The procedure for obtaining reimbursement for out-of-area dialysis care is described in the "Requests for Payment" section.

Your Cost Share. You pay the following for these covered Services related to dialysis:

- Equipment and supplies for home hemodialysis and home peritoneal dialysis: **no charge**
- One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment: **no charge**
- Hemodialysis and peritoneal dialysis treatment: **no charge**
- Hospital inpatient care (including room and board, drugs, imaging, laboratory, and other diagnostic and treatment Services, and Plan Physician Services): **no charge**

For the following Services related to "Dialysis Care," refer to these sections

- Durable medical equipment for home use (refer to "Durable Medical Equipment ("DME") for Home Use")
- Hospital inpatient care (refer to "Hospital Inpatient Care")
- Office visits not described in this "Dialysis Care" section (refer to "Outpatient Care")
- Kidney disease education (refer to "Health Education")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")
- Telehealth Visits (refer to "Telehealth Visits")

Dialysis care exclusion(s)

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

Durable Medical Equipment ("DME") for Home Use

DME coverage rules

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

- The item is intended for repeated use
- The item is primarily and customarily used to serve a medical purpose

- The item is generally useful only to an individual with an illness or injury
- The item is appropriate for use in the home (or another location used as your home as defined by Medicare)

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

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

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

DME for diabetes

We cover the following diabetes blood-testing supplies and equipment and insulin-administration devices if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Insulin pumps and supplies to operate the pump

- **Your Cost Share**. You pay the following for covered DME for diabetes (including repair or replacement of covered equipment):
- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices): **no charge**
- Insulin pumps and supplies to operate the pump: **no charge**

Base DME Items

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

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

- **Your Cost Share**. You pay the following for covered Base DME Items: **no charge**.

Other covered DME items

- If all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met, we cover the following other DME items (including repair or replacement of covered equipment):
- Bed accessories for a hospital bed when bed extension is required
- Heel or elbow protectors to prevent or minimize advanced pressure relief equipment use
- Iontophoresis device to treat hyperhidrosis when antiperspirants are contraindicated and the hyperhidrosis has created medical complications (for example, skin infection) or preventing daily living activities
- Nontherapeutic continuous glucose monitoring devices and related supplies
- Peak flow meters
- Resuscitation bag if tracheostomy patient has significant secretion management problems, needing lavage and suction technique aided by deep breathing via resuscitation bag

- **Your Cost Share**. You pay the following for other covered DME items: **no charge**.

Outside our Service Area

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

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices) from a Plan Pharmacy
- Canes (standard curved handle)
- Crutches (standard)
- Nebulizers and their supplies for the treatment of pediatric asthma
- Peak flow meters from a Plan Pharmacy

For the following Services related to "Durable Medical Equipment ("DME") for Home Use," refer to these sections

- Dialysis equipment and supplies required for home hemodialysis and home peritoneal dialysis (refer to "Dialysis Care")
- Diabetes urine testing supplies and insulin-administration devices other than insulin pumps (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Durable medical equipment related to the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Insulin and any other drugs administered with an infusion pump (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

DME for home use exclusion(s)

- Comfort, convenience, or luxury equipment or features
- Dental appliances
- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including devices intended to provide additional support for recreational or sports activities)
- Hygiene equipment
- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car, unless covered in accord with Medicare guidelines
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies)
- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to misuse

Fertility Services

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

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

Diagnosis and treatment of infertility

For purposes of this "Diagnosis and treatment of infertility" section, "infertility" means not being able to get pregnant or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception or having a medical or other demonstrated condition that is recognized by a Plan Physician as a cause of infertility. We cover the following:

- Services for the diagnosis and treatment of infertility
- Artificial insemination

You pay the following for covered infertility Services:

- Office visits: **a $10 Copayment per visit**
- Most outpatient surgery and outpatient procedures when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or provided in any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **a $10 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a $10 Copayment per procedure**
- Outpatient imaging: **no charge**
- Outpatient laboratory: **no charge**
- Outpatient diagnostic Services: **no charge**
- Outpatient administered drugs: **no charge**
- Hospital inpatient care (including room and board, imaging, laboratory, and other diagnostic and treatment Services, and Plan Physician Services): **no charge**

- Note: Administered drugs and products are medications and products that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility

For the following Services related to "Fertility Services," refer to these sections

- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Fertility Services exclusion(s)

- Services to reverse voluntary, surgically induced infertility
- Semen and eggs (and Services related to their procurement and storage)
- Assisted reproductive technology Services, such as ovum transplants, gamete intrafallopian transfer (GIFT), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT)

Health Education

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

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

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

Note: Our Health Education Department offers a comprehensive self-management workshop to help members learn the best choices in exercise, diet, monitoring, and medications to manage and control diabetes. Members may also choose to receive diabetes self-management training from a program outside our Plan that is recognized by the American Diabetes Association (ADA) and approved by Medicare. Also, our Health Education Department offers education to teach kidney care and help members make informed decisions about their care.

Your Cost Share. You pay the following for these covered Services:

- Covered health education programs, which may include programs provided online and counseling over the phone: **no charge**
- Other covered individual counseling when the office visit is solely for health education: **a $10 Copayment per visit**
- Health education provided during an outpatient consultation or evaluation covered in another part of this *EOC*: **no additional Cost Share beyond the Cost Share required in that other part of this *EOC***
- Covered health education materials: **no charge**

Hearing Services

We cover the following:

- Hearing exams with an audiologist to determine the need for hearing correction: **a $10 Copayment per visit**
- Physician Specialist Visits to diagnose and treat hearing problems: **a $10 Copayment per visit**

Hearing aids

- We cover the following Services related to hearing aids:
- A **$500 Allowance** for each ear toward the purchase price of a hearing aid (including fitting, counseling, adjustment, cleaning, and inspection) every 36 months when prescribed by a Plan Physician or by a Plan Provider who is an audiologist. We will cover hearing aids for both ears only if both aids are required to provide significant improvement that is not obtainable with only one hearing aid. We will not provide the Allowance if we have provided an Allowance toward (or otherwise covered) a hearing aid within the previous 36 months. Also, the Allowance can only be used at the initial point of sale. If you do not use all of your Allowance at the initial point of sale, you cannot use it later

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

For the following Services related to "Hearing Services," refer to these sections

- Services related to the ear or hearing other than those described in this section, such as outpatient care to treat an ear infection or outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits and Your Cost Share" section)
- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Hearing Services exclusion(s)

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

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. We cover part-time or intermittent home health care in accord with Medicare guidelines. Home health care services are covered up to the number of visits and length of time that are determined to be medically necessary under the Member's home health treatment plan and no more than the limits established under Medicare guidelines, only if all of the following are true:

- You are substantially confined to your home
- Your condition requires the Services of a nurse, physical therapist, or speech therapist or continued need for an occupational therapist (home health aide Services are not covered unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide)
- A Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home
- The Services are provided inside our Service Area
- **Your Cost Share.** We cover home health care Services at **no charge**.

For the following Services related to "Home Health Care," refer to these sections

- Dialysis care (refer to "Dialysis Care")
- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy, urological, and wound care supplies (refer to "Ostomy, Urological, and Wound Care Supplies")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient physical, occupational, and speech therapy visits (refer to "Outpatient Care")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Home health care exclusion(s)

- Care in the home if the home is not a safe and effective treatment setting

Hospice Care

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

If you have Medicare Part A, you may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs its normal course. Your hospice doctor can be a Plan Provider or a Non–Plan Provider. Covered Services include:

- Drugs for symptom control and pain relief
- Short-term respite care
- Home care

For hospice services and services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our Plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.

For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need nonemergency, non–urgently needed

services that are covered under Medicare Part A or B and that are not related to your terminal condition, your cost for these services depends on whether you use a Plan Provider:

- If you obtain the covered services from a Plan Provider, you only pay the Plan Cost Share amount
- If you obtain the covered services from a Non–Plan Provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare)

- **For services that are covered by our Plan but are not covered by Medicare Part A or B:** We will continue to cover Plan-covered Services that are not covered under Part A or B whether or not they are related to your terminal condition. You pay your Plan Cost Share amount for these Services.

- **For drugs that may be covered by our plan's Part D benefit:** Drugs are never covered by both hospice and our plan at the same time. For more information, please see "What if you're in a Medicare-certified hospice" in the "Outpatient Prescription Drugs, Supplies, and Supplements" section.

Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.

For more information about Original Medicare hospice coverage, visit **https://www.medicare.gov**, and under "Search Tools," choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or call **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048)**, 24 hours a day, seven days a week.

Special note if you do not have Medicare Part A

We cover the hospice Services listed below at **no charge** only if all of the following requirements are met:

- You are not entitled to Medicare Part A
- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside our Service Area (or inside California but within 15 miles or 30 minutes from our Service Area if you live outside our Service Area, and you have been a Senior Advantage Member continuously since before January 1, 1999, at the same home address)
- The Services are provided by a licensed hospice agency that is a Plan Provider
- A Plan Physician determines that the Services are necessary for the palliation and management of your terminal illness and related conditions

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

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

- We also cover the following hospice Services only during periods of crisis when they are Medically Necessary to achieve palliation or management of acute medical symptoms:
- Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
- Short-term inpatient care required at a level that cannot be provided at home

Meals

Following discharge from a hospital due to congestive heart failure, we cover up to two meals per day in a consecutive four-week period, once per calendar year as follows:

- As part of the discharge process, someone from your care team will initiate a referral valid for 30 days. Once the referral is approved, the meal delivery vendor will contact you with meal options and arrange meal delivery. You can contact our Member Service Contact Center if you have any questions about your referral
- In addition to meals for general health, there are menus to support specific conditions and diets

Your Cost Share. We cover home-delivered meals at **no charge**.

Meals exclusion

- You are discharged to another facility that provides meals (for example, inpatient rehabilitation)

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when the Services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, as amended in the most recently issued edition, *("DSM")* that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the *DSM* identifies as something other than a "mental disorder." For example, the *DSM* identifies relational problems as something other than a "mental disorder," so we do not cover services (such as couples counseling or family counseling) for relational problems.

"Mental Disorders" include the following conditions:

- Severe Mental Illness of a person of any age
- Serious Emotional Disturbance of a Child Under Age 18

In addition to the Services described in this Mental Health Services section, we also cover other Services that are Medically Necessary to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness, if the Medical Group authorizes a written referral (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Outpatient mental health Services

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

- Individual and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient Services for the purpose of monitoring drug therapy

Intensive psychiatric treatment programs. We cover the following intensive psychiatric treatment programs at a Plan Facility:

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

Your Cost Share. You pay the following for these covered Services:

- Individual mental health evaluation and treatment: **a $10 Copayment per visit**
- Group mental health treatment: **a $5 Copayment per visit**
- Partial hospitalization: **no charge**
- Other intensive psychiatric treatment programs: **no charge**

Residential treatment

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

- Individual and group mental health evaluation and treatment
- Medical services
- Medication monitoring
- Room and board
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are

administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, please refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section)

- Discharge planning

- **Your Cost Share.** We cover residential mental health treatment Services at **no charge**.

Inpatient psychiatric hospitalization

We cover care for acute psychiatric conditions in a Medicare-certified psychiatric hospital.

Your Cost Share. We cover inpatient psychiatric hospital Services at **no charge**.

For the following Services related to "Mental Health Services," refer to these sections

- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Telehealth Visits (refer to "Telehealth Visits")

Opioid Treatment Program Services

Opioid use disorder treatment Services are covered under Part B of Original Medicare. Members of our plan receive coverage for these Services through our plan.

Your Cost Share: You pay the following for these covered Services:

- FDA-approved opioid agonist and antagonist clinically-administered Medicare Part B drugs when provided by an Opioid Treatment Program: **no charge**
- Substance use counseling: **no charge**
- Individual and group therapy: **no charge**
- Toxicology testing: **no charge**

Ostomy, Urological, and Wound Care Supplies

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

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

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

- **Your Cost Share**: You pay the following for covered ostomy, urological, and wound care supplies: **20 percent Coinsurance**.

Ostomy, urological, and wound care supplies exclusion(s)

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services

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

- Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans: **no charge**
- Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds: **no charge**
- Nuclear medicine: **no charge**
- Routine preventive retinal photography screenings: **no charge**
- Routine laboratory tests to monitor the effectiveness of dialysis: **no charge**
- Hemoglobin (A1c) testing for diabetes, Low-Density Lipoprotein (LDL) testing for heart disease, International Normalized Ratio (INR) for persons with liver disease or certain blood disorders, and

glucose quantitative blood tests not covered at $0 under Original Medicare: **no charge**

- All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available): **no charge**
- Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs and EEGs): **no charge**
- Radiation therapy: **no charge**
- Ultraviolet light treatments: **no charge**

For the following Services related to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," refer to these sections

- Outpatient imaging and laboratory Services that are Preventive Services, such as routine mammograms, bone density scans, and laboratory screening tests (refer to "Preventive Services")
- Outpatient procedures that include imaging and diagnostic Services (refer to "Outpatient surgeries and procedures")
- Services related to diagnosis and treatment of infertility, artificial insemination, or assisted reproductive technology ("ART") Services (refer to "Fertility Services")

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section when prescribed as follows:

- Items prescribed by providers, within the scope of their licensure and practice, and in accord with our drug formulary guidelines
- Items prescribed by the following Non–Plan Providers unless a Plan Physician determines that the item is not Medically Necessary or the drug is for a sexual dysfunction disorder:
  - dentists if the drug is for dental care
  - Non–Plan Physicians if the Medical Group authorizes a written referral to the Non–Plan Physician (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section) and the drug, supply, or supplement is covered as part of that referral
  - Non–Plan Physicians if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described in the "Requests for Payment" section)
- The item meets the requirements of our applicable drug formulary guidelines (our Medicare Part D formulary or our formulary applicable to non–Part D items)
- You obtain the item at a Plan Pharmacy or through our mail-order service, except as otherwise described under "Certain items from Non–Plan Pharmacies" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. Please refer to our *Kaiser Permanente Pharmacy Directory* for the locations of Plan Pharmacies in your area. Plan Pharmacies can change without notice and if a pharmacy is no longer a Plan Pharmacy, you must obtain covered items from another Plan Pharmacy, except as otherwise described under "Certain items from Non–Plan Pharmacies" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section
- Your prescriber must either accept Medicare or file documentation with the Centers for Medicare & Medicaid Services showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed

In addition to our plan's Part D and medical benefits coverage, if you have Medicare Part A, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please see "What if you're in a Medicare-certified hospice" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section.

Obtaining refills by mail

Most refills are available through our mail-order service, but there are some restrictions. A Plan Pharmacy, our *Kaiser Permanente Pharmacy Directory*, or our website at **kp.org/refill** can give you more information about obtaining refills through our mail-order service. Please check with your local Plan Pharmacy if you have a question about whether your prescription can be mailed. Items available through our mail-order service are subject to change at any time without notice.

Certain items from Non–Plan Pharmacies

Generally, we cover drugs filled at a Non–Plan Pharmacy only when you are not able to use a Plan Pharmacy. If you cannot use a Plan Pharmacy, here are

the circumstances when we would cover prescriptions filled at a Non–Plan Pharmacy.

- The drug is related to covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section. Note: Prescription drugs prescribed and provided outside of the United States and its territories as part of covered Emergency Services or Urgent Care are covered up to a 30-day supply in a 30-day period. These drugs are covered under your medical benefits, and are not covered under Medicare Part D. Therefore, payments for these drugs do not count toward reaching the Part D Catastrophic Coverage Stage
- For Medicare Part D covered drugs, the following are additional situations when a Part D drug may be covered:
  - if you are traveling outside our Service Area, but in the United States and its territories, and you become ill or run out of your covered Part D prescription drugs. We will cover prescriptions that are filled at a Non–Plan Pharmacy according to our Medicare Part D formulary guidelines
  - if you are unable to obtain a covered drug in a timely manner inside our Service Area because there is no Plan Pharmacy within a reasonable driving distance that provides 24-hour service. We may not cover your prescription if a reasonable person could have purchased the drug at a Plan Pharmacy during normal business hours
  - if you are trying to fill a prescription for a drug that is not regularly stocked at an accessible Plan Pharmacy or available through our mail-order pharmacy (including high-cost drugs)
  - if you are not able to get your prescriptions from a Plan Pharmacy during a disaster

In these situations, please check first with our Member Service Contact Center to see if there is a Plan Pharmacy nearby. You may be required to pay the difference between what you pay for the drug at the Non–Plan Pharmacy and the cost that we would cover at Plan Pharmacy.

Payment and reimbursement. If you go to a Non–Plan Pharmacy for the reasons listed, you may have to pay the full cost (rather than paying just your Copayment or Coinsurance) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a request for reimbursement as described in the "Requests for Payment" section. If we pay for the drugs you obtained from a Non–Plan Pharmacy, you may still pay more for your drugs than what you would have paid if you had gone to a Plan Pharmacy because you may be responsible for paying the difference between Plan Pharmacy Charges and the price that the Non–Plan Pharmacy charged you.

What if you're in a Medicare-certified hospice

If you have Medicare Part A, drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication, or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive 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 receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. For more information about Medicare Part D coverage and what you pay, please see "Medicare Part D drugs" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section.

Medicare Part D drugs

Medicare Part D covers most outpatient prescription drugs if they are sold in the United States and approved for sale by the federal Food and Drug Administration. Our Part D formulary includes drugs that can be covered under Medicare Part D according to Medicare requirements. Please refer to our "Medicare Part D drug formulary *(2021 Comprehensive Formulary)*" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section for more information about this formulary.

Cost Share for Medicare Part D drugs. Unless you reach the Catastrophic Coverage Stage in a calendar year, you will pay the following Cost Share for covered Medicare Part D drugs:

- Generic drugs: **a $10 Copayment for up to a 100-day supply**
- Brand-name and specialty drugs: **a $20 Copayment for up to a 100-day supply**
- Injectable Part D vaccines: **no charge**
- Emergency contraceptive pills: **no charge**

- The following insulin-administration devices at **a $10 Copayment** for up to a 100-day supply: needles, syringes, alcohol swabs, and gauze

Catastrophic Coverage Stage. All Medicare prescription drug plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend **$6,550** out-of-pocket during 2021. When the total amount you have paid for your Cost Share reaches **$6,550**, you will pay the following for the remainder of 2021:

- **a $3 Copayment** per prescription for insulin administration devices and generic drugs
- **a $10 Copayment** per prescription for brand-name and specialty drugs
- Injectable Part D vaccines: **no charge**
- Emergency contraceptive pills: **no charge**

Note: Each year, effective on January 1, the Centers for Medicare & Medicaid Services may change coverage thresholds and catastrophic coverage Copayments that apply for the calendar year. We will notify you in advance of any change to your coverage.

These payments <u>are</u> included in your out-of-pocket costs. When you add up your out-of-pocket costs, you can include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in this "Outpatient Prescription Drugs, Supplies, and Supplements" section):

- The amount you pay for drugs when you are in the Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our Plan

It matters who pays:

- If you make these payments yourself, they are included in your out-of-pocket costs
- These payments are also included if they are made on your behalf by certain other individuals or organizations. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the Indian Health Service. Payments made by Medicare's Extra Help Program are also included

These payments are <u>not</u> included in your out-of-pocket costs. When you add up your out-of-pocket costs, you are not allowed to include any of these types of payments for prescription drugs:

- The amount you contribute, if any, toward your group's Premium
- Drugs you buy outside the United States and its territories
- Drugs that are not covered by our Plan
- Drugs you get at an out-of-network pharmacy that do not meet our Plan's requirements for out-of-network coverage
- Prescription drugs covered by Part A or Part B
- Payments you make toward prescription drugs not normally covered in a Medicare prescription drug plan
- Payments for your drugs that are made or funded by group health plans, including employer health plans
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and Veterans Affairs
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)

Reminder: If any other organization such as the ones described above pays part or all of your out-of-pocket costs for Part D drugs, you are required to tell our Plan. Call our Member Service Contact Center to let us know (phone numbers are on the cover of this *EOC*).

Keeping track of Medicare Part D drugs. The *Part D Explanation of Benefits* is a document you will get for each month you use your Part D prescription drug coverage. The *Part D Explanation of Benefits* will tell you the total amount you, or others on your behalf, have spent on your prescription drugs and the total amount we have paid for your prescription drugs. A *Part D Explanation of Benefits* is also available upon request from our Member Service Contact Center.

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, and prescription Copayments. This "Extra Help" also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for "Extra Help." Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

You may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week;
- The Social Security Office at **1-800-772-1213** (TTY users call **1-800-325-0778**), 7 a.m. to 7 p.m., Monday through Friday (applications); or
- Your state Medicaid office (applications). See the "Important Phone Numbers and Resources" section for contact information

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect Cost Share amount when you get your prescription at a Plan Pharmacy, our plan has established a process that allows you either to request assistance in obtaining evidence of your proper Cost Share level, or, if you already have the evidence, to provide this evidence to us. If you aren't sure what evidence to provide us, please contact a Plan Pharmacy or our Member Service Contact Center. The evidence is often a letter from either your 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 Plan Pharmacy when obtaining covered Part D prescriptions so that we may charge you the appropriate Cost Share amount until the Centers for Medicare & Medicaid Services updates its records to reflect your current status. Once the Centers for Medicare & Medicaid Services updates its records, you will no longer need to present the evidence to the Plan Pharmacy. Please provide your evidence in one of the following ways so we can forward it to the Centers for Medicare & Medicaid Services 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 Plan Pharmacy or your local Member Services office at a Plan Facility

When we receive the evidence showing your Cost Share level, we will update our system so that you can pay the correct Cost Share when you get your next prescription at our Plan Pharmacy. If you overpay your Cost Share, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future Cost Share. If our Plan Pharmacy hasn't collected a Cost Share from you and is carrying your Cost Share as a debt owed by you, we may make the payment directly to our Plan Pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please call our Member Service Contact Center if you have questions.

If you qualify for "Extra Help," we will send you an *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*), that explains your costs as a Member of our plan. If the amount of your "Extra Help" changes during the year, we will also mail you an updated *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*.

Medicare Part D drug formulary *(2021 Comprehensive Formulary)*

Our Medicare Part D formulary is a list of covered drugs selected by our plan in consultation with a team of health care providers that represents the drug therapies believed to be a necessary part of a quality treatment program. Our formulary must meet requirements set by Medicare and is approved by Medicare. Our formulary includes drugs that can be covered under Medicare Part D according to Medicare requirements. For a complete, current listing of the Medicare Part D prescription drugs we cover, please visit our website at **kp.org/seniorrx** or call our Member Service Contact Center.

The presence of a drug on our formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition. Our drug formulary guidelines allow you to obtain Medicare Part D prescription drugs if a Plan Physician determines that they are Medically Necessary for your condition. If you disagree with your Plan Physician's determination, refer to "Your Part D Prescription Drugs: How to Ask for a Coverage Decision or Make an Appeal" in the "Coverage Decisions, Appeals, and Complaints" section.

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

About specialty drugs. Specialty drugs are high-cost drugs that are on our specialty drug list. If your Plan Physician prescribes more than a 30-day supply for an outpatient drug, you may be able to obtain more than a

30-day supply at one time, up to the day supply limit for that drug. However, most specialty drugs are limited to a 30-day supply in any 30-day period. Your Plan Pharmacy can tell you if a drug you take is one of these drugs.

Preferred generic and generic drugs listed in the formulary will be subject to the generic drug Copayment or Coinsurance listed under "Copayment and Coinsurance for Medicare Part D drugs" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. Preferred and nonpreferred brand-name drugs and specialty tier drugs listed in the formulary will be subject to the brand-name Copayment or Coinsurance listed under "Copayment and Coinsurance for Medicare Part D drugs" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. Please note that sometimes a drug may appear more than once on our *2021 Comprehensive Formulary*. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

You can get updated information about the drugs our plan covers by visiting our website at **kp.org/seniorrx**. You may also call our Member Service Contact Center to find out if your drug is on the formulary or to request an updated copy of our formulary.

We may make certain changes to our formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. The kinds of formulary changes we may make include:

- Adding or removing drugs from the formulary
- Adding prior authorizations or other restrictions on a drug

If we remove drugs from the formulary or add prior authorizations or restrictions on a drug, and you are taking the drug affected by the change, you will be permitted to continue receiving that drug at the same level of Cost Share for the remainder of the calendar year. However, if a brand-name drug is replaced with a new generic drug, or our formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change. We will notify you of the change at least 30 days before the date that the change becomes effective or provide you with at least a month's supply at the Plan Pharmacy. This will give you an opportunity to work with your physician to switch to a different drug that we cover or request an exception. (If a drug is removed from our formulary because the drug has been recalled, we will not give 30 days' notice before removing the drug from the formulary. Instead, we will remove the drug immediately and notify members taking the drug about the change as soon as possible.)

If your drug isn't listed on your copy of our formulary, you should first check the formulary on our website, which we update when there is a change. In addition, you may call our Member Service Contact Center to be sure it isn't covered. If Member Services confirms that we don't cover your drug, you have two options:

- You may ask your Plan Physician if you can switch to another drug that is covered by us
- You or your Plan Physician may ask us to make an exception (a type of coverage determination) to cover your Medicare Part D drug. See the "Coverage Decisions, Complaints, and Appeals" section for more information on how to request an exception

Transition policy. If you recently joined our plan, you may be able to get a temporary supply of a Medicare Part D drug you were previously taking that may not be on our formulary or has other restrictions, during the first 90 days of your membership. Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their Plan Physicians to decide if they should switch to a different drug that we cover or request a Part D formulary exception in order to get coverage for the drug. Please refer to our formulary or our website, **kp.org/seniorrx**, for more information about our Part D transition coverage.

Medicare Part D exclusions (non–Part D drugs). By law, certain types of drugs are not covered by Medicare Part D. If a drug is not covered by Medicare Part D, any amounts you pay for that drug will not count toward reaching the Catastrophic Coverage Stage. A Medicare Prescription Drug Plan can't cover a drug under Medicare Part D in the following situations:

- The drug would be covered under Medicare Part A or Part B
- Drug purchased outside the United States and its territories
- Off-label uses (meaning for uses other than those indicated on a drug's label as approved by the federal Food and Drug Administration) of a prescription drug, except in cases where the use is supported by certain reference books. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.) If the use is not supported by one of these references, known as compendia, then the drug is

considered a non–Part D drug and cannot be covered under Medicare Part D coverage

In addition, by law, certain types of drugs or categories of drugs are not covered under Medicare Part D. These drugs include:

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

Note: In addition to the coverage provided under this Medicare Part D plan, you also have coverage for non–Part D drugs described under "Home infusion therapy," "Outpatient drugs covered by Medicare Part B," "Certain intravenous drugs, supplies, and supplements," and "Outpatient drugs, supplies, and supplements not covered by Medicare" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. If a drug is not covered under Medicare Part D, please refer to those headings for information about your non–Part D drug coverage.

Other prescription drug coverage. If you have additional health care or drug coverage from another plan, you must provide that information to our plan. The information you provide helps us calculate how much you and others have paid for your prescription drugs. In addition, if you lose or gain additional health care or prescription drug coverage, please call our Member Service Contact Center to update your membership records.

Home infusion therapy

We cover home infusion supplies and drugs at **no charge** if all of the following are true:

- Your prescription drug is on our Medicare Part D formulary
- We approved your prescription drug for home infusion therapy
- Your prescription is written by a network provider and filled at a network home-infusion pharmacy

Outpatient drugs covered by Medicare Part B

In addition to Medicare Part D drugs, we also cover the limited number of outpatient prescription drugs that are covered by Medicare Part B. The following are the types of drugs that Medicare Part B covers:

- Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services
- Drugs you take using durable medical equipment (such as nebulizers) that were prescribed by a Plan Physician
- Clotting factors you give yourself by injection if you have hemophilia
- Immunosuppressive drugs, if Medicare paid for the transplant (or a group plan was required to pay before Medicare paid for it)
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens
- Certain oral anticancer drugs and antinausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when Medically Necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases

Your Cost Share for Medicare Part B drugs. You pay the following for Medicare Part B drugs:

- Generic drugs: **a $10 Copayment for up to a 100-day supply**
- Brand-name drugs, specialty drugs, and compounded products: **a $20 Copayment for up to a 100-day supply**

Certain intravenous drugs, supplies, and supplements

We cover certain self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as an intravenous or intraspinal-infusion) at **no charge** for up to a 30-day supply. In addition, we cover the supplies and equipment

required for the administration of these drugs at **no charge**.

Outpatient drugs, supplies, and supplements not covered by Medicare

If a drug, supply, or supplement is not covered by Medicare Part B or D, we cover the following additional items in accord with our non–Part D drug formulary:

- Drugs for which a prescription is required by law that are not covered by Medicare Part B or D. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary applicable to non–Part D items
- Diaphragms, cervical caps, contraceptive rings, and contraceptive patches
- Disposable needles and syringes needed for injecting covered drugs, pen delivery devices, and visual aids required to ensure proper dosage (except eyewear), that are not covered by Medicare Part B or D
- Inhaler spacers needed to inhale covered drugs
- Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing
- FDA-approved medications for tobacco cessation, including over-the-counter medications when prescribed by a Plan Physician

Your Cost Share for other outpatient drugs, supplies, and supplements. Your Cost Share for these items is as follows:

- Generic items (that are not described elsewhere in this *EOC*): **a $10 Copayment for up to a 100-day supply**
- Brand-name items, specialty drugs, and compounded products (that are not described elsewhere in this *EOC*): **a $20 Copayment for up to a 100-day supply**
- Drugs prescribed for the treatment of sexual dysfunction disorders: **25 percent Coinsurance for up to a 100-day supply**
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria) and elemental dietary enteral formula when used as a primary therapy for regional enteritis: **no charge** for up to a 30-day supply
- Diabetes urine-testing supplies: **no charge** for up to a 100-day supply
- Tobacco cessation drugs: **no charge**. For over-the-counter medications, we cover up to two 100-day supplies per calendar year

Note: If Charges for the drug, supply, or supplement are less than the Copayment, you will pay the lesser amount.

Non–Part D drug formulary. The non–Part D drug formulary includes a list of drugs that our Pharmacy and Therapeutics Committee has approved for our Members. Our Pharmacy and Therapeutics Committee, which is primarily composed of Plan Physicians, selects drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature. The Pharmacy and Therapeutics Committee meets at least quarterly to consider additions and deletions based on new information or drugs that become available. To find out which drugs are on the formulary for your plan, please visit our website at **kp.org/formulary**. If you would like to request a copy of the non–Part D drug formulary for your plan, please call our Member Service Contact Center. Note: The presence of a drug on the drug formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition.

Drug formulary guidelines allow you to obtain nonformulary prescription drugs (those not listed on our drug formulary for your condition) if they would otherwise be covered and a Plan Physician determines that they are Medically Necessary. If you disagree with your Plan Physician's determination that a nonformulary prescription drug is not Medically Necessary, you may file an appeal as described in the "Coverage Decisions, Appeals, and Complaints" section. Also, our non–Part D formulary guidelines may require you to participate in a behavioral intervention program approved by the Medical Group for specific conditions and you may be required to pay for the program.

About specialty drugs. Specialty drugs are high-cost drugs that are on our specialty drug list. If your Plan Physician prescribes more than a 30-day supply for an outpatient drug, you may be able to obtain more than a 30-day supply at one time, up to the day supply limit for that drug. However, most specialty drugs are limited to a 30-day supply in any 30-day period. Your Plan Pharmacy can tell you if a drug you take is one of these drugs.

Drug utilization review

We conduct drug utilization reviews to make sure that you are getting safe and appropriate care. These reviews are especially important if you have more than one doctor who prescribes your medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

- Possible medication errors
- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
- Drugs that are inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking
- Drug allergies
- Drug dosage errors
- Unsafe amounts of opioid pain medications

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Drug management program

We have a program that can help make sure our members safely use their prescription opioid medications, or other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide you are at risk for misusing or abusing your opioid or benzodiazepine medications, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one pharmacy.
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one doctor.
- Limiting the amount of opioid or benzodiazepine medications we will cover for you.

If we decide that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the terms of the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use. If you think we made a mistake or you disagree with our determination that you are at-risk for prescription drug abuse or the limitation, you and your prescriber have the right to ask us for an appeal. See the "Coverage Decisions, Appeals, and Complaints" section for information about how to ask for an appeal.

The DMP may not apply to you if you have certain medical conditions, such as cancer, you are receiving hospice, palliative, or end-of-life care, or you live in a long-term care facility.

Medication therapy management program

We offer a medication therapy management program at no additional cost to Members who have multiple medical conditions, who are taking many prescription drugs, and who have high drug costs. This program was developed for us by a team of pharmacists and doctors. We use this medication therapy management program to help us provide better care for our members. For example, this program helps us make sure that you are using appropriate drugs to treat your medical conditions and help us identify possible medication errors.

If you are selected to join a medication therapy management program, we will send you information about the specific program, including information about how to access the program.

ID card at Plan Pharmacies

You must present your Kaiser Permanente ID card when obtaining covered items from Plan Pharmacies, including those that are not owned and operated by Kaiser Permanente. If you do not have your ID card, the Plan Pharmacy may require you to pay Charges for your covered items, and you will have to file a claim for reimbursement as described in the "Requests for Payment" section.

Notes:

- If Charges for a covered item are less than the Copayment, you will pay the lesser amount
- Durable medical equipment used to administer drugs, such as diabetes insulin pumps (and their supplies) and diabetes blood-testing equipment (and their supplies) are not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section (instead, refer to "Durable Medical Equipment ("DME") for Home Use" in this "Benefits and Your Cost Share" section)
- Except for vaccines covered by Medicare Part D, drugs administered to you in a Plan Medical Office or during home visits are not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section (instead, refer to "Outpatient Care" in this "Benefits and Your Cost Share" section)
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility are not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section (instead, refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care" in this "Benefits and Your Cost Share" section)

Outpatient prescription drugs, supplies, and supplements limitations

Day supply limit. Plan Physicians determine the amount of a drug or other item that is Medically Necessary for a particular day supply for you. Upon payment of the Cost Share specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, you will receive the supply prescribed up to a 100-day supply in a 100-day period. However, the Plan Pharmacy may reduce the day supply dispensed to a 30-day supply in any 30-day period at the Cost Share listed in this "Outpatient Prescription Drugs, Supplies, and Supplements" section if the Plan Pharmacy determines that the drug is in limited supply in the market or a 31-day supply in any 31-day period if the item is dispensed by a long term care facility's pharmacy. Plan Pharmacies may also limit the quantity dispensed as described under "Utilization management." If you wish to receive more than the covered day supply limit, then the additional amount is not covered and you must pay Charges for any prescribed quantities that exceed the day supply limit. The amount you pay for noncovered drugs does not count toward reaching the Catastrophic Coverage Stage.

Utilization management. For certain items, we have additional coverage requirements and limits that help promote effective drug use and help us control drug plan costs. Examples of these utilization management tools are:

- **Quantity limits:** The Plan Pharmacy may reduce the day supply dispensed at the Cost Share specified in this "Outpatient Drugs, Supplies, and Supplements" section to a 30-day supply or less in any 30-day period for specific drugs. Your Plan Pharmacy can tell you if a drug you take is one of these drugs. In addition, we cover episodic drugs prescribed for the treatment of sexual dysfunction up to a maximum of eight doses in any 30-day period, up to 16 doses in any 60-day period, or up to 27 doses in any 100-day period. Also, when there is a shortage of a drug in the marketplace and the amount of available supplies, we may reduce the quantity of the drug dispensed accordingly and charge one cost share
- **Generic substitution:** When there is a generic version of a brand-name drug available, Plan Pharmacies will automatically give you the generic version, unless your Plan Physician has specifically requested a formulary exception because it is Medically Necessary for you to receive the brand-name drug instead of the formulary alternative

Outpatient prescription drugs, supplies, and supplements exclusions

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging
- Compounded products unless the active ingredient in the compounded product is listed on one of our drug formularies
- Drugs prescribed to shorten the duration of the common cold
- Prescription drugs for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the prescription drug). This exclusion does not apply to:
  - ♦ insulin
  - ♦ over-the-counter tobacco cessation drugs and contraceptive drugs
  - ♦ an entire class of prescription drugs when one drug within that class becomes available over-the-counter
  - ♦ drugs covered by Medicare Parts B or D

Preventive Services

We cover a variety of Preventive Services in accord with Medicare guidelines. The list of Preventive Services is subject to change by the Centers for Medicare & Medicaid Services. These Preventive Services are subject to all coverage requirements described in this "Benefits and Your Cost Share" section and all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. If you have questions about Preventive Services, please call our Member Service Contact Center.

Note: If you receive any other covered Services that are not Preventive Services during or subsequent to a visit that includes Preventive Services on the list, you will pay the applicable Cost Share for those other Services. For example, if laboratory tests or imaging Services ordered during a preventive office visit are not Preventive Services, you will pay the applicable Cost Share for those Services.

Your Cost Share. You pay the following for covered Preventive Services:

- Abdominal aortic aneurysm screening prescribed during the one-time "Welcome to Medicare" preventive visit: **no charge**
- Annual Wellness visit: **no charge**
- Bone mass measurement: **no charge**

- Breast cancer screening (mammograms): **no charge**
- Cardiovascular disease risk reduction visit (therapy for cardiovascular disease): **no charge**
- Cardiovascular disease testing: **no charge**
- Cervical and vaginal cancer screening: **no charge**
- Colorectal cancer screening, including flexible sigmoidoscopies, colonoscopies, and fecal occult blood tests: **no charge**
- Depression screening: **no charge**
- Diabetes screening, including fasting glucose tests: **no charge**
- Diabetes self-management training: **no charge**
- Glaucoma screening: **no charge**
- HIV screening: **no charge**
- Immunizations (including the vaccine) covered by Medicare Part B such as Hepatitis B, influenza, and pneumococcal vaccines that are administered to you in a Plan Medical Office: **no charge**
- Lung cancer screening: **no charge**
- Medical nutrition therapy for kidney disease and diabetes: **no charge**
- Medicare diabetes prevention program: **no charge**
- Obesity screening and therapy to promote sustained weight loss: **no charge**
- Prostate cancer screening exams, including digital rectal exams and Prostate Specific Antigens (PSA) tests: **no charge**
- Screening and counseling to reduce alcohol misuse: **no charge**
- Screening for sexually transmitted infections (STIs) and counseling to prevent STIs: **no charge**
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use): **no charge**
- "Welcome to Medicare" preventive visit: **no charge**

Prosthetic and Orthotic Devices

Prosthetic and orthotic devices coverage rules

We cover the prosthetic and orthotic devices specified in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage includes fitting and adjustment of these devices, their repair or replacement, and Services to determine whether you need a prosthetic or orthotic device. If we cover a replacement device, then you pay the Cost Share that you would pay for obtaining that device.

Base prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the items described in this "Base prosthetic and orthotic devices" section.

Internally implanted devices. We cover prosthetic and orthotic devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, in accord with Medicare guidelines, if they are implanted during a surgery that we are covering under another section of this "Benefits and Your Cost Share" section. We cover these devices at **no charge**.

External devices. We cover the following external prosthetic and orthotic devices at **20 percent Coinsurance**:

- Prosthetics and orthotics in accord with Medicare guidelines. These include, but are not limited to, braces, prosthetic shoes, artificial limbs, and therapeutic footwear for severe diabetes-related foot disease in accord with Medicare guidelines
- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- After Medically Necessary removal of all or part of a breast, prosthesis including custom-made prostheses when Medically Necessary
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments

- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Enteral pump and supplies
- Tracheostomy tube and supplies
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

Other covered prosthetic and orthotic devices

- If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the following items described in this "Other covered prosthetic and orthotic devices" section:
- Prosthetic devices required to replace all or part of an organ or extremity, in accord with Medicare guidelines
- Vacuum erection device for sexual dysfunction
- Certain surgical boots following surgery when provided during an outpatient visit
- Orthotic devices required to support or correct a defective body part, in accord with Medicare guidelines

Your Cost Share. You pay the following for other covered prosthetic and orthotic devices: **20 percent Coinsurance**.

For the following Services related to "Prosthetic and Orthotic Devices," refer to these sections

- Eyeglasses and contact lenses, including contact lenses to treat aniridia or aphakia (refer to "Vision Services")
- Eyewear following cataract surgery (refer to "Vision Services")
- Hearing aids other than internally implanted devices described in this section (refer to "Hearing Services")
- Injectable implants (refer to "Administered drugs and products" under "Outpatient Care")

Prosthetic and orthotic devices exclusion(s)

- Dental appliances
- Nonrigid supplies not covered by Medicare, such as elastic stockings and wigs, except as otherwise described above in this "Prosthetic and Orthotic Devices" section and the "Ostomy, Urological, and Wound Care Supplies" section
- Comfort, convenience, or luxury equipment or features
- Repair or replacement of device due to misuse
- Shoes, shoe inserts, arch supports, or any other footwear, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications
- Prosthetic and orthotic devices not intended for maintaining normal activities of daily living (including devices intended to provide additional support for recreational or sports activities)
- Nonconventional intraocular lenses (IOLs) following cataract surgery (for example, presbyopia-correcting IOLs). You may request and we may provide insertion of presbyopia-correcting IOLs or astigmatism-correcting IOLs following cataract surgery in lieu of conventional IOLs. However, you must pay the difference between Charges for nonconventional IOLs and associated services and Charges for insertion of conventional IOLs following cataract surgery

Reconstructive Surgery

We cover the following reconstructive surgery Services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Plan Physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible
- Following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

Your Cost Share. You pay the following for covered reconstructive surgery Services:

- Outpatient surgery and outpatient procedures when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **a $10 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a $10 Copayment per procedure**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this "Benefits and Your Cost Share" section (for example, radiology

procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

- Hospital inpatient care (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services): **no charge**

For the following Services related to "Reconstructive Surgery," refer to these sections

- Office visits not described in this "Reconstructive Surgery" section (refer to "Outpatient Care")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Telehealth Visits (refer to "Telehealth Visits")

Reconstructive surgery exclusion(s)

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance

Religious Nonmedical Health Care Institution Services

Care in a Medicare-certified Religious Nonmedical Health Care Institution (RNHCI) is covered by our Plan under certain conditions. Covered Services in an RNHCI are limited to nonreligious aspects of care. To be eligible for covered Services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital or Skilled Nursing Facility care. You may get Services furnished in the home, but only items and Services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "nonexcepted" medical treatment. ("Excepted" medical treatment is a Service or treatment that you receive involuntarily or that is required under federal, state, or local law. "Nonexcepted" medical treatment is any other Service or treatment.) Your stay in the RNHCI is not covered by us unless you obtain authorization (approval) in advance from us.

Note: Covered Services are subject to the same limitations and Cost Share required for Services provided by Plan Providers as described in this "Benefits and Your Cost Share" section.

Services Associated with Clinical Trials

If you participate in a Medicare-approved clinical trial, Original Medicare (and not Senior Advantage) pays most of the routine costs for the covered Services you receive as part of the trial. When you are in a clinical trial, you may stay enrolled in Senior Advantage and continue to get the rest of your care (the care that is not related to the trial) through our plan.

If you want to participate in a Medicare-approved clinical trial, you don't need to get a referral from a Plan Provider, and the providers that deliver your care as part of the clinical trial don't need to be Plan Providers. Although you don't need to get a referral from a Plan Provider, you do need to tell us before you start participating in a clinical trial so we can keep track of your Services.

Once you join a Medicare-approved clinical trial, you are covered for routine Services you receive as part of the trial. Routine Services include room and board for a hospital stay that Medicare would pay for even if you weren't in a trial, an operation or other medical procedure if it is part of the trial, and treatment of side effects and complications arising from the new care.

Original Medicare pays most of the cost of the covered Services you receive as part of the trial. After Medicare has paid its share of the cost for these Services, we will pay the difference between the cost share of Original Medicare and your Cost Share as a Member of our plan. This means you will pay the same amount for the routine Services you receive as part of the trial as you would if you received these Services from our plan.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the trial and how much you owe. Please see the "Requests for Payment" section for more information about submitting requests for payment.

To learn more about joining a clinical trial, please refer to the "Medicare and Clinical Research Studies"

brochure. To get a free copy, call Medicare directly toll free at **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week, or visit **https://www.medicare.gov** on the Web.

Services associated with clinical trials exclusion(s)

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

- The new item or service that the study is testing, unless Medicare would cover the item or service even if you were not in a study
- Items or services provided only to collect data, and not used in your direct health care
- Services that are customarily provided by the research sponsors free of charge to enrollees in the clinical trial
- Items and services provided solely to determine trial eligibility

Skilled Nursing Facility Care

Inside our Service Area, we cover up to 100 days per benefit period of skilled inpatient Services in a Plan Skilled Nursing Facility and in accord with Medicare guidelines. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care (defined in accord with Medicare guidelines). A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required. Note: If your Cost Share changes during a benefit period, you will continue to pay the previous Cost Share amount until a new benefit period begins.

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment in accord with our durable medical equipment formulary and Medicare guidelines if Skilled Nursing Facilities ordinarily furnish the equipment
- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Whole blood, red blood cells, plasma, platelets, and their administration
- Medical supplies
- Physical, occupational, and speech therapy in accord with Medicare guidelines
- Respiratory therapy

Your Cost Share. We cover these Skilled Nursing Facility Services at **no charge**.

For the following Services related to "Skilled Nursing Facility Care," refer to these sections

- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

Non–Plan Skilled Nursing Facility care

Generally, you will get your Skilled Nursing Facility care from Plan Facilities. However, under certain conditions listed below, you may be able to receive covered care from a non–Plan facility, if the facility accepts our Plan's amounts for payment.

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides Skilled Nursing Facility care)
- A Skilled Nursing Facility where your spouse is living at the time you leave the hospital

Substance Use Disorder Treatment

We cover Services specified in this "Substance Use Disorder Treatment" section only when the Services are for the diagnosis or treatment of Substance Use Disorders. A "Substance Use Disorder" is a condition identified as a "substance use disorder" in the most recently issued edition of the *Diagnostic and Statistical Manual of Mental Disorders ("DSM")*.

Outpatient substance use disorder treatment

We cover the following Services for treatment of substance use disorders:

- Day-treatment programs

- Individual and group substance use disorder counseling
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms

Your Cost Share. You pay the following for these covered Services:

- Individual substance use disorder evaluation and treatment: **a $10 Copayment per visit**
- Group substance use disorder treatment: **a $5 Copayment per visit**
- Intensive outpatient and day-treatment programs: **a $5 Copayment per day**

Residential treatment

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

- Individual and group substance use disorder counseling
- Medical services
- Medication monitoring
- Room and board
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, please refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section)
- Discharge planning

- **Your Cost Share.** We cover residential substance use disorder treatment Services at **no charge**.

Inpatient detoxification

We cover hospitalization in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Your Cost Share. We cover inpatient detoxification Services at **no charge**.

For the following Services related to "Substance Use Disorder Treatment," refer to these sections

- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient self-administered drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Telehealth Visits (refer to "Telehealth Visits")

Telehealth Visits

Telehealth Visits between you and your provider are intended to make it more convenient for you to receive covered Services, when a Plan Provider determines it is medically appropriate for your medical condition. You have the option of receiving these services either through an in-person visit or via telehealth. You may receive covered Services via Telehealth Visits, when available and if the Services would have been covered under this *EOC* if provided in person. If you choose to receive Services via telehealth, then you must use a Plan Provider that currently offers the service via telehealth. We offer the following telehealth Services:

- Telehealth Services for monthly end-stage renal disease--related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the Member's home
- Telehealth Services for diagnosis, evaluation or treatment of symptoms of an acute stroke
- Virtual check-ins (for example, by phone or video chat) with your doctor for 5 to 10 minutes if all of the following are true:
  - you're not a new patient
  - the check-in isn't related to an office visit within the past 7 days
  - 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 (except weekends and holidays) if all of the following are true:
  - you're not a new patient
  - the check-in isn't related to an office visit within the past 7 days
  - the check-in 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—if you are an established patient

Your Cost Share. You pay the following types for Telehealth Visits with Primary Care Physicians, Non-Physician Specialists, and Physician Specialists:

- Interactive video visits: **no charge**
- Scheduled telephone visits: **no charge**

Transplant Services

We cover transplants of organs, tissue, or bone marrow in accord with Medicare guidelines and if the Medical Group provides a written referral for care to a transplant facility as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

After the referral to a transplant facility, the following applies:

- If either the Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover Services you receive before that determination is made
- Health Plan, Plan Hospitals, the Medical Group, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with our guidelines for Services for living transplant donors, we provide certain donation-related Services for a donor, or an individual identified by the Medical Group as a potential donor, whether or not the donor is a Member. These Services must be directly related to a covered transplant for you, which may include certain Services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Please call our Member Service Contact Center for questions about donor Services

Your Cost Share. For covered transplant Services that you receive, you will pay the **Cost Share you would pay if the Services were not related to a transplant**. For example, see "Hospital Inpatient Care" in this "Benefits and Your Cost Share" section for the Cost Share that applies for hospital inpatient care.

We provide or pay for donation-related Services for actual or potential donors (whether or not they are Members) in accord with our guidelines for donor Services at **no charge**.

For the following Services related to "Transplant Services," refer to these sections

- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Vision Services

We cover the following:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses: **a $10 Copayment per visit**
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **a $10 Copayment per visit**
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **a $10 Copayment per visit**

Optical Services

We cover the Services described in this "Optical Services" section at Plan Medical Offices or Plan Optical Sales Offices.

The date we provide an Allowance toward (or otherwise cover) an item described in this "Optical Services" section is the date on which you order the item. For example, if we last provided an Allowance toward an item you ordered on May 1, 2019, and if we provide an Allowance not more than once every 24 months for that type of item, then we would not provide another Allowance toward that type of item until on or after May 1, 2021. You can use the Allowances under this "Optical Services" section only when you first order an item. If you use part but not all of an Allowance when you first order an item, you cannot use the rest of that Allowance later.

Eyeglasses and contact lenses following cataract surgery. We cover at **no charge** one pair of eyeglasses or contact lenses (including fitting or dispensing) following each cataract surgery that includes insertion of an intraocular lens at Plan Medical Offices or Plan Optical Sales Offices when prescribed by a physician or optometrist. When multiple cataract surgeries are needed, and you do not obtain eyeglasses or contact lenses between procedures, we will only cover one pair of eyeglasses or contact lenses after any surgery. If the eyewear you purchase costs more than what Medicare covers for someone who has Original Medicare (also known as "Fee-for-Service Medicare"), you pay the difference.

Special contact lenses

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist: **no charge**
- In accord with Medicare guidelines, we cover corrective lenses (including contact lens fitting and dispensing) and frames (and replacements) for Members who are aphakic (for example, who have had a cataract removed but do not have an implanted intraocular lens (IOL) or who have congenital absence of the lens): **no charge**
- If a Plan Physician or Plan Optometrist prescribes contact lenses (other than contact lenses for aniridia or aphakia) that will provide a significant improvement in your vision that eyeglass lenses cannot provide, we cover either one pair of contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses (including fitting and dispensing) not more than once every 24 months at **no charge**. We will not cover any contact lenses under this "Special contact lenses" section if we provided an allowance toward (or otherwise covered) a contact lens within the previous 24 months, but not including any of the following:
  - ♦ contact lenses for aniridia or aphakia
  - ♦ contact lenses we provided an Allowance toward (or otherwise covered) under "Eyeglasses and contact lenses following cataract surgery" in this "Vision Services" section as a result of cataract surgery

Eyeglasses and contact lenses. We provide a single **$150 Allowance** toward the purchase price of any or all of the following not more than once every 24 months when a physician or optometrist prescribes an eyeglass lens (for eyeglass lenses and frames) or contact lens (for contact lenses):

- Eyeglass lenses when a Plan Provider puts the lenses into a frame
  - ♦ we cover a clear balance lens when only one eye needs correction
  - ♦ we cover tinted lenses when Medically Necessary to treat macular degeneration or retinitis pigmentosa
- Eyeglass frames when a Plan Provider puts two lenses (at least one of which must have refractive value) into the frame
- Contact lenses, fitting, and dispensing

We will not provide the Allowance if we have provided an Allowance toward (or otherwise covered) eyeglass lenses or frames within the previous 24 months.

Replacement lenses. If you have a change in prescription of at least .50 diopter in one or both eyes within 12 months of the initial point of sale of an eyeglass lens or contact lens that we provided an Allowance toward (or otherwise covered) we will provide an Allowance toward the purchase price of a replacement item of the same type (eyeglass lens, or contact lens, fitting, and dispensing) for the eye that had the .50 diopter change. The Allowance toward one of these replacement lenses is **$30** for a single vision eyeglass lens or for a contact lens (including fitting and dispensing) and **$45** for a multifocal or lenticular eyeglass lens.

For the following Services related to "Vision Services," refer to these sections

- Services related to the eye or vision other than Services covered under this "Vision Services" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits and Your Cost Share" section)

Vision Services exclusion(s)

- Eyeglass or contact lens adornment, such as engraving, faceting, or jeweling
- Industrial frames or safety eyeglasses, when required as a condition of employment
- Items that do not require a prescription by law (other than eyeglass frames), such as eyeglass holders, eyeglass cases, and repair kits
- Lenses and sunglasses without refractive value, except as described in this "Vision Services" section
- Low vision devices
- Replacement of lost, broken, or damaged contact lenses, eyeglass lenses, and frames

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this