January 1 – December 31, 2020

Evidence of Coverage

Your Medicare Health Benefits and Services as a Member of Kaiser Permanente Medicare Plus (Cost)

This booklet gives you the details about your Medicare health care coverage from January 1 to December 31, 2020. It explains how to get coverage for the health care services you need. This is an important legal document. Please keep it in a safe place.

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

This document is available in Braille or large print if you need it by calling Member Services (phone numbers are printed on the back cover of this booklet).

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2021. The provider network may change at any time. You will receive notice when necessary.

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PBPs 017, 021, 022, 030
MD/VA-MPCOST-EOC-DP (01/20)
OMB Approval 0938-1051 (Expires: December 31, 2021)

KAISER PERMANENTE®

2020 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. You will find a detailed list of topics at the beginning of each chapter.

CHAPTER 1. Getting started as a member

SECTION 1. Introduction

Section 1.1 You are enrolled in Medicare Plus, which is a Medicare Cost Plan

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, Kaiser Permanente Medicare Plus.

There are different types of Medicare health plans. Medicare Plus is a Medicare Cost Plan. This plan does not include Part D prescription drug coverage. Like all Medicare health plans, this Medicare Cost Plan is approved by Medicare and run by a private company.

Coverage under this plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at **https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information.

Section 1.2 What is the Evidence of Coverage booklet about?

This **Evidence of Coverage** booklet tells you how to get your Medicare medical care covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of our plan.

This **Evidence of Coverage** (**EOC**) describes four Medicare Plus plans. The following plans are included in this **Evidence of Coverage** and they do **not** include Medicare Part D prescription drug coverage:

- Kaiser Permanente Medicare Plus High w/o D (AB) (Cost) — referred to in this **Evidence of Coverage** as the "**High Option**" plan for members with Medicare Parts A and B.
- Kaiser Permanente Medicare Plus Std w/o D (AB) (Cost) — referred to in this **Evidence of Coverage** as the "**Standard Option**" plan for members with Medicare Parts A and B.
- Kaiser Permanente Medicare Plus Basic w/o D (AB) (Cost) — referred to in this **Evidence of Coverage** as the "**Basic Option**" plan for members with Medicare Parts A and B.
- Kaiser Permanente Medicare Plus Basic w/o D (B) (Cost) — referred to in this **Evidence of Coverage** as the "**Basic Part B Only Option**" plan for members without Medicare Part A coverage.

If you are not certain which plan you are enrolled in, please call Member Services or refer to the cover of your **Annual Notice of Changes**. This **Evidence of Coverage** also describes "optional supplemental benefits" called Advantage Plus. References to these benefits apply to you only if you are enrolled in Advantage Plus and are only available to Standard or High plan members.

The words "coverage" and "covered services" refer to the medical care and services available to you as a member of our plan.

It's important for you to learn what our plan's rules are and what services are available to you. We encourage you to set aside some time to look through this **Evidence of Coverage** booklet.

If you are confused or concerned or just have a question, please contact Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the Evidence of Coverage

It's part of our contract with you

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

The contract is in effect for the months in which you are enrolled in Medicare Plus between January 1, 2020, and December 31, 2020.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of our plan after December 31, 2020. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2020.

Medicare must approve our plan each year

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

SECTION 2. What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have Medicare Part B (or you have both Part A and Part B) (Section 2.2 below tells you about Medicare Part A and Medicare Part B).
- – *and* – you live in our geographic service area (Section 2.3 below describes our service area).
- – *and* – you are a United States citizen or are lawfully present in the United States.
- – *and* – you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer.

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies).
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is our plan service area for Medicare Plus

Although Medicare is a federal program, our plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these cities and counties in Virginia: Alexandria City, Arlington, Fairfax City, Fairfax County, Falls Church City, Loudoun County, Manassas City, Manassas Park City**,** and Prince William County.

Also, our service area includes Carroll County in Maryland and these parts of counties in Maryland, in the following ZIP codes only:

- Calvert County: 20639, 20678, 20689, 20714, 20732, 20736, and 20754.
- Frederick County: 21701, 21702, 21703, 21704, 21705, 21709, 21710, 21714, 21716, 21717, 21718, 21754, 21755, 21758, 21759, 21762, 21769, 21770, 21771, 21774, 21775, 21777, 21790, 21792, and 21793.

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). When you move, you will have a special enrollment period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

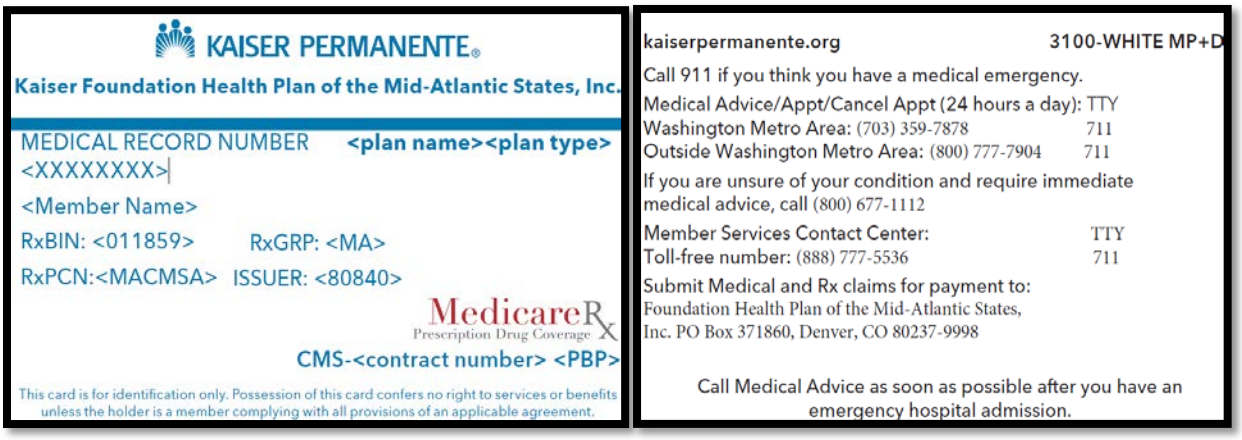
Section 2.4 U.S. citizen or lawful presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify us if you are not eligible to remain a member on this basis. We must disenroll you if you do not meet this requirement.

SECTION 3. What other materials will you get from us?

Section 3.1 Your plan membership card—use it to get the care covered by our plan

We will send you a plan membership card. You should use this card whenever you get covered services from a Medicare Plus network provider. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:



If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. Phone numbers for Member Services are printed on the back cover of this booklet.

Because Medicare Plus is a Medicare Cost Plan, you should also **keep your red, white, and blue Medicare card with you**. As a Cost Plan member, if you receive Medicare-covered services (except for emergency or urgent care) from an out-of-network provider or when you are outside of our service area, these services will be paid for by Original Medicare, not our plan. In these cases, you will be responsible for Original Medicare deductibles and coinsurance. (If you receive emergency or urgent care from an out-of-network provider or when you are outside of our service area, our plan will pay for these services.) It is important that you keep your red, white, and blue Medicare card with you for when you receive services paid for under Original Medicare.

Section 3.2 The Provider Directory: Your guide to all providers in our network

The **Provider Directory** lists our network providers and durable medical equipment suppliers.

What are "network providers"?

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement

with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and suppliers is available on our website at **kp.org/directory**. However, members of our plan may also get services from out-of-network providers. If you get care from out-of-network providers, you will pay the cost-sharing amounts under Original Medicare.

If you don't have your copy of the **Provider Directory**, you can request a copy from Member Services (phone numbers are printed on the back cover of this booklet). You may ask Member Services for more information about our network providers, including their qualifications. You can view or download the **Provider Directory** at **kp.org/directory**. Both Member Services and our website can give you the most up-to-date information about our network providers.

SECTION 4. Your monthly premium for our plan

Section 4.1 How much is your plan premium?

As a member of our plan, you pay a monthly plan premium. The table below shows the monthly plan premium amount for each plan we are offering in the service area. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Medicare Plus plan	Monthly plan premium
High Option This plan applies to members who have Medicare Parts A and B and are enrolled in this plan. • If you are **not** enrolled in Advantage Plus: • If you are enrolled in Advantage Plus:	 **$105** **$130***
Standard Option This plan applies to members who have Medicare Parts A and B and are enrolled in this plan. • If you are **not** enrolled in Advantage Plus: • If you are enrolled in Advantage Plus:	 **$25** **$50***
Basic Option This plan applies to members who have Medicare Parts A and B and are enrolled in this plan.	**$10**

Medicare Plus plan	Monthly plan premium
Basic Part B Only Option This plan applies to members who have Medicare Part B only and are enrolled in this plan.	**$422**
*****If you signed up for extra benefits, also called "optional supplemental benefits" (Advantage Plus), then you pay an additional premium each month for these extra benefits. If you have any questions about your plan premiums, please call Member Services and see Chapter 4, Section 2.2, for more information.	

SECTION 5. More information about your monthly premium?

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. And most plan members pay a premium for Medicare Part B. You must continue paying your Medicare Part B premium to remain a member of our plan.

Your copy of **Medicare & You** 2020 gives you information about Medicare premiums in the section called "2020 Medicare Costs." This explains how the Medicare Part B premium differs for people with different incomes. Everyone with Medicare receives a copy of **Medicare & You** each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of **Medicare & You** 2020 from the Medicare website (**https://www.medicare.gov**) or you can order a printed copy by phone at **1-800-MEDICARE (1-800-633-4227),** 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**.

Section 5.1 There are several ways you can pay your plan premium

There are four ways you can pay your plan premium. You will pay by check (Option 1) unless you tell us that you want your premium automatically deducted from your bank (Options 2 and 3) or your Social Security check (Option 4). To sign up for Option 2 or 4, or to change your selection at any time, please call Member Services and tell us which option you want.

If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.

Option 1: You can pay by check or money order

You may send your monthly plan premium directly to us. We must receive your check made payable to "**Kaiser Permanente**" on or before the first of the coverage month at the following address:

Kaiser Permanente
Membership Accounting Department
PO Box 64199
Baltimore, MD 21264-4199

Note: You cannot pay in person.

Option 2: You can sign up for electronic funds transfer (EFT)

Instead of paying by check, you can have your monthly plan premium automatically withdrawn from your bank account. Please call Member Services to learn how to start or stop automatic payments of your plan premium and other details about this option, such as when your monthly withdrawal will occur.

Option 3: You can make a one-time payment using a credit card by phone

You can also make a payment using a credit card over the phone by calling our Membership Administration Department at **1-800-777-7902**, 8 a.m. to 4:30 p.m., Monday through Friday.

Option 4: You can have our plan premium taken out of your monthly Social Security check

You can have our plan premium taken out of your monthly Social Security check. Contact Member Services for more information about how to pay your monthly plan premium this way. We will be happy to help you set this up. (Phone numbers for Member Services are printed on the back cover of this booklet.)

What to do if you are having trouble paying your plan premium

Your plan premium is due in our office by the first day of the coverage month. If we have not received your premium payment by the 10th day of the coverage month, we will send you a notice telling you the amount you owe. We have the right to pursue collections of any premiums you owe. If we don't receive your premium payment within 60 days and you are enrolled in our optional supplemental benefits package (Advantage Plus), we may terminate those benefits and you will not be able to sign up for the benefits again until October 15 for coverage to become effective January 1.

If you are having trouble paying your plan premium on time, please contact Member Services to see if we can direct you to programs that will help with your plan premium. Phone numbers for Member Services are printed on the back cover of this booklet.

Section 5.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for our plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

SECTION 6. Please keep your plan membership record up-to-date

Section 6.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage, including your primary care provider.

The doctors, hospitals, and other providers in our network need to have correct information about you. These network providers use your membership record to know what services are covered and the cost-sharing amounts for you. Because of this, it is very important that you help us keep your information up-to-date.

Let us know about these changes:

- Changes to your name, your address, or your phone number.
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid).
- If you have any liability claims, such as claims from an automobile accident.
- If you have been admitted to a nursing home.
- If you receive care in an out-of-area or out-of-network hospital or emergency room.
- If your designated responsible party (such as a caregiver) changes.
- If you are participating in a clinical research study.

If any of this information changes, please let us know by calling Member Services (phone numbers are printed on the back cover of this booklet).

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 8 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 7. We protect the privacy of your personal health information

Section 7.1 We make sure that your health information is protected

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

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.3 of this booklet.

SECTION 8. How other insurance works with our plan

Section 8.1 Which plan pays first when you have other insurance?

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

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

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

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

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

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2. Important phone numbers and resources

SECTION 1. Kaiser Permanente Medicare Plus contacts (how to contact us, including how to reach Member Services at our plan)

How to contact our plan's Member Services

For assistance with claims, billing, or membership card questions, please call or write to Medicare Plus Member Services. We will be happy to help you.

Method	Member Services – contact information
CALL	**1-888-777-5536** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Kaiser Permanente Member Services 2101 East Jefferson Street Rockville, Maryland 20852
WEBSITE	**kp.org**

How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision we have made. You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes.

For more information about asking for a coverage decision or making an appeal or a complaint about your medical care, see Chapter 7, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." You may call us if you have questions about our coverage decision, appeal, or complaint processes.

Method	Coverage decisions, appeals, or complaints about medical care – contact information
CALL	**1-888-777-5536** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.

Method	Coverage decisions, appeals, or complaints about medical care – contact information
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
FAX	**1-866-640-9826**
WRITE	Kaiser Permanente Member Services 2101 East Jefferson Street Rockville, Maryland 20852
WEBSITE	**kp.org**
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to **https://www.medicare.gov/MedicareComplaintForm/home.aspx**.

Where to send a request asking us to pay for our share of the cost for medical care you have received

For more information about situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 5, "Asking us to pay our share of a bill you have received for covered medical services."

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," for more information.

Method	Payment requests – contact information
CALL	**1-888-777-5536** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
FAX	**866-640-9826**
WRITE	Kaiser Permanente Member Services 2101 East Jefferson Street Rockville, Maryland 20852
WEBSITE	**kp.org**

SECTION 2. **Medicare** (how to get help and information directly from the federal Medicare program)

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage and Medicare Cost Plan organizations, including our plan.

Method	Medicare – contact information
CALL	**1-800-MEDICARE** or **1-800-633-4227** Calls to this number are free. 24 hours a day, 7 days a week.
TTY	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	**https://www.medicare.gov** This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options, with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about our plan: • **Tell Medicare about your complaint:** You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to **https://www.medicare.gov/MedicareComplaintForm/home.aspx**. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

Method	Medicare – contact information
	If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.)

SECTION 3. State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Here is a list of the State Health Insurance Assistance Programs in each state we serve:

- In Maryland, the SHIP is called **Maryland Department of Aging**.
- In Virginia, the SHIP is called **Virginia Insurance Counseling and Assistance Program**.

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

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

Method	Maryland Department of Aging – contact information
CALL	**410-767-1100** or toll free **1-844-627-5465**
TTY	**711**
WRITE	301 West Preston St., Suite 1007, Baltimore, MD 21201
WEBSITE	**https://www.aging.maryland.gov/Pages/default.aspx**

Method	Virginia Insurance Counseling and Assistance Program – contact information
CALL	**804-662-9333** or toll free **1-800-552-3402**

TTY	**711**
WRITE	1610 Forest Avenue, Suite 100, Henrico, VA 23229
WEBSITE	**https://www.vda.virginia.gov**

SECTION 4. **Quality Improvement Organization** (paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Maryland and Virginia, the Quality Improvement Organization is called Livanta.

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

You should contact Livanta in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	Livanta (Maryland's and Virginia's QIO) – contact information
CALL	**1-888-396-4646** 9 a.m. to 5 p.m., Monday through Friday. 11 a.m. to 3 p.m., weekends and holidays.
TTY	**1-888-985-2660** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-833-868-4057**
WRITE	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
WEBSITE	**www.livantaqio.com/en**

SECTION 5. Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

Method	Social Security – contact information
CALL	**1-800-772-1213** Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	**1-800-325-0778** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday.
WEBSITE	**https://www.ssa.gov**

SECTION 6. **Medicaid** (a joint federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

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

- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact the Medicaid agency for your state listed below.

Method	Maryland Medical Assistance Program/HealthChoice – contact information
CALL	**410-767-5800** or toll free **1-877-463-3464** 8:30 a.m. to 5 p.m., Monday through Friday.
TTY	**1-800-735-2258** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Contact the Department of Social Services (DSS) in the city or county where you live.
WEBSITE	**https://www.mmcp.dhmh.maryland.gov**

Method	Virginia Department of Medical Assistance Services – contact information
CALL	**804-786-7933** 8 a.m. to 5 p.m., Monday through Friday.
TTY	**800-343-0634** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Contact the Department of Social Services (DSS) in the city or county where you live.
WEBSITE	**http://www.dmas.virginia.gov/**

SECTION 7. How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – contact information
CALL	**1-877-772-5772** Calls to this number are free. If you press "0," you may speak with an RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9 a.m. to 12 p.m. on Wednesday. If you press "1," you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	**1-312-751-4701** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free.
WEBSITE	**https://secure.rrb.gov/**

SECTION 8. Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. Phone numbers for Member Services are printed on the back cover of this booklet. You may also call **1-800-MEDICARE** (**1-800-633-4227**; TTY: **1-877-486-2048**) with questions related to your Medicare coverage under this plan.

CHAPTER 3. Using our plan's coverage for your medical services

SECTION 1. Things to know about getting your medical care covered as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered. It gives you definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by our plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4, "Medical Benefits Chart (what is covered and what you pay)."

Section 1.1 What are "network providers" and "covered services"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- "**Providers**" are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- "**Network providers**" are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan.
- "**Covered services**" include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

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

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

We will generally cover your medical care as long as:

- **The care you receive is included in our plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary**. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You generally must receive your care from a network provider for our plan to cover the services.**
  - If we do not cover services you receive from an out-of-network provider, the services will be covered by Original Medicare if they are Medicare-covered services. Except for emergency or urgently needed services, if you get services covered by Original Medicare

from an out-of-network provider then you must pay Original Medicare's cost-sharing amounts. For information on Original Medicare's cost-sharing amounts, call **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

- You should get supplemental benefits from a network provider. If you get covered supplemental benefits, such as dental care, from an out-of-network provider, then you must pay the entire cost of the service.
- If an out-of-network provider sends you a bill that you think we should pay, please contact Member Services (phone numbers are printed on the back cover of this booklet). Generally, it is best to ask an out-of-network provider to bill Original Medicare first, and then to bill us for the remaining amount. We may require the out-of-network provider to bill Original Medicare. We will then pay any applicable Medicare coinsurance and deductibles minus your copayments on your behalf.

- **You have a network primary care provider** (a PCP) who is providing and overseeing your care. As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
  - In most situations, your network PCP must give you approval in advance before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral" (for more information about this, see Section 2.3 in this chapter).
  - Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 in this chapter).

SECTION 2. Use providers in our network to get your medical care

Section 2.1 You must choose a primary care provider (PCP) to provide and oversee your medical care

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

As a member, you must choose one of our available network providers to be your primary care provider. Your primary care provider is a physician in family medicine, adult medicine, general practice, or obstetrics/gynecology who meets state requirements and is trained to give you primary medical care.

Your PCP will provide most of your health care and will arrange or coordinate your covered care with other Medical Group physicians and other providers. If you need certain types of covered services or supplies, you must get approval in advance from your PCP. For specialty care and other services, your PCP will need to get prior authorization (prior approval) from us as described in Section 2.3 in this chapter.

You are free to get care from other Medical Group PCPs if your PCP is not available, and at any Kaiser Permanente medical office.

How do you choose your PCP?

You may choose a primary care provider from any of our available network physicians who practice in these specialties: internal medicine, family medicine, and pediatrics. Also, women can choose any available primary care provider from obstetrics/gynecology. Your PCP must be a network physician, unless we designate otherwise. If you do not choose a PCP, then one will be selected for you from the available Medical Group physicians.

When you make a selection, it is effective immediately. To learn how to choose a primary care provider, please call Member Services. You can also make your selection at **kp.org**. If there is a particular network specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our network of providers and you would have to find a new PCP.

To change your PCP, call Member Services. When you call, be sure to tell Member Services if you are seeing specialists or getting other covered services that need your PCP's approval (such as home health services and durable medical equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Member Services will tell you when the change to your new PCP will take effect. Generally, changes are effective the first of the month following the date when we receive your request.

Section 2.2 What kinds of medical care can you get without getting approval in advance from your PCP?

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

- Routine women's health care, which includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider.
- Flu shots and Hepatitis B vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible (for example, when you are temporarily outside of our service area).
- If you visit the service area of another Kaiser Permanente region, you can receive certain care covered under this **Evidence of Coverage** from designated providers in that service area. Please call Member Services or our away from home travel line at **1-951-268-3900** (24 hours a day, 7 days a week except holidays), TTY **711**, for more information about getting care when visiting another Kaiser Permanente region's service area, including coverage information and facility locations in parts of California, Colorado, Georgia, Hawaii, Oregon, and Washington.
- Outpatient observation services.
- Mental health visits, as long as you receive services from a network provider.

- Kidney disease education visits, as long as you receive services from a network provider.
- Preventive dental care, as long as you receive services from a network provider.
- Preventive care, except for abdominal aortic aneurysm screening, bone mass measurement, cardiovascular screening, colorectal cancer screening, and medical nutrition therapy.

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

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

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

Referrals from your PCP

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

When your PCP prescribes specialized treatment, he or she will give you a referral (approval in advance) to see a network specialist or certain other network providers. However, for some types of specialty care referrals, your PCP may need to get approval in advance from our plan. If there is a particular network hospital that you want to use, check first to be sure your network provider makes referrals to that hospital.

If you are seeing an out-of-network specialist when you enroll in our plan, you will be required in most instances to switch to a network specialist. If your current specialist is not a network specialist and you wish to continue to receive services from that out-of-network specialist, you may continue to do so under your Original Medicare benefits, if he/she participates in the Medicare program. In that instance, you will be required to pay Original Medicare cost-sharing because the services will not be covered by our plan.

Prior authorization

For the services and items listed below and in Chapter 4, Sections 2.1 and 2.2, your network provider will need to get approval in advance from our plan or Medical Group (this is called getting "prior authorization"). Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals. If you get these services and items without prior authorization by our plan or Medical Group, the care will not be covered by our plan and you will have to pay Original Medicare's out-of-pocket amounts for the care.

- **Inpatient care:** For nonemergency admissions, the Medical Group and our plan will coordinate your care and determine which hospital you will be admitted. Your network provider must receive prior authorization from us for nonemergency admissions, including admissions to behavioral health, skilled nursing facilities, or other inpatient settings. We will determine the most appropriate facility for care. Depending upon your medical needs, we may transfer you from one network hospital or other inpatient setting, to another network hospital

where Medical Group physicians are always on duty. In addition, we may transfer you from one network skilled nursing facility to another where Medical Group physicians make rounds and are available for urgent care.

- Medically necessary **transgender surgery** and associated procedures.
- Care from a **religious nonmedical health care institution** described in Section 6 of this chapter.
- **Network specialty care:** When your PCP believes that you need specialty care, he or she will request authorization from us. If specialty care is medically necessary, we will send you a written referral to authorize an initial consultation and/or a specified number of visits with a network specialist. After your initial consultation with the network specialist, you must then return to your PCP unless we have authorized more visits as specified in the written referral that we gave you. Don't return to the network specialist after your initial consultation visit unless we have authorized additional visits in your referral. Otherwise, the services will not be covered and you will be responsible for paying Original Medicare cost-sharing and out-of-pocket expenses, instead of our plan's cost-sharing amounts. Here are some other things you should know about obtaining specialty care:
  - If you need to see a network specialist frequently because you have been diagnosed with a condition or disease that requires ongoing specialized care, your PCP and your attending network specialist may develop a treatment plan that allows you to see the network specialist without additional referrals. Your PCP must contact us and your network specialist must use our criteria when creating your treatment plan, and the network specialist will need to get authorization before starting any treatment.
- **Out-of-network specialty care:** If your network provider decides that you require covered services not available from network providers, he or she will recommend to the Medical Group that you be referred to an out-of-network provider inside or outside our service area. The appropriate Medical Group designee will authorize the services if he or she determines that the covered services are medically necessary and are not available from a network provider. Referrals to out-of-network providers will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your network provider what services have been authorized. If the out-of-network specialist wants you to come back for more care, be sure to check if the referral covers more visits to the specialist. If it doesn't, please contact your network provider.
- After we are notified that you need **post-stabilization care** from an out-of-network provider following emergency care, we will discuss your condition with the out-of-network provider. If we decide that you require post-stabilization care and that this care would be covered if you received it from a network provider, we will authorize your care from the out-of-network provider only if we cannot arrange to have a network provider (or other designated provider) provide the care. Please see Section 3.1 in this chapter for more information.

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

If you find out your doctor or specialist is leaving your plan, please contact us at **1-888-777-5536** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m., so we can assist you in finding a new provider and managing your care.

SECTION 3. How to get covered services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

A "medical emergency" is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible**. Call **911** for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency**. We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The number to call is listed on the back of your plan membership card.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere inside the United States or its territories. We cover ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

In addition, if you are enrolled in the High or Standard Option plans, you may get covered emergency medical care (including ambulance) when you need it anywhere in the world. However, you may have to pay for the services and file a claim for reimbursement (see Chapter 5 for more information).

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be either covered by our plan or Original Medicare. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow and we may choose to move you to a hospital where Medical Group physicians are always on duty. Our plan will cover your post-stabilization care if the services are provided by network providers, authorized by our plan, or the care is covered out-of-area urgent care. Otherwise, your post-stabilization care will be covered by Original Medicare and you will have to pay Original Medicare cost-sharing for post-stabilization care.

What if it wasn't a medical emergency?

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

However, after the doctor has said that it was not an emergency, we will cover additional care only if you go to a network provider to get the additional care. If you get additional care from an out-of-network provider after the doctor says it was not an emergency, you will normally have to pay Original Medicare's cost-sharing.

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

What are "urgently needed services"?

"Urgently needed services" are a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in our service area when you have an urgent need for care?

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible, and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses specially trained to help assess medical symptoms and provide advice over the phone, when medically

appropriate. Whether you are calling for advice or to make an appointment, you can speak to an advice nurse. They can often answer questions about a minor concern, tell you what to do if a network facility is closed, or advise you about what to do next, including making a same-day urgent care appointment for you if it's medically appropriate.

To speak with an advice nurse or make an appointment, please call **1-800-777-7904** (TTY **711**), 24 hours a day, seven days a week, or refer to your **Provider Directory** for appointment and advice telephone numbers.

What if you are outside our service area when you have an urgent need for care?
When you are outside the service area and cannot get care from a network provider, we will cover urgently needed services that you get from any provider under the following circumstances:

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

For High or Standard Option plan members, we cover worldwide urgent care services. For Basic Option plan members, we cover urgent care inside United States and its territories.

Section 3.3 Getting care during a disaster

If the governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from us.

Please visit the following website—**kp.org**—for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, we will allow you to obtain care from out-of-network providers at in-network cost-sharing.

SECTION 4. What if you are billed directly for the full cost of your covered services?

Section 4.1 You can ask us to pay our share of the cost for covered services

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5, "Asking us to pay our share of a bill you have received for covered medical services," for information about what to do.

Section 4.2 If services are not covered by our plan or Original Medicare, you must pay the full cost

We cover all medical services that are medically necessary, listed in the Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by Original Medicare or are not covered by our plan. Also you will be responsible for payment if you obtain a plan service that was obtained out-of-network and was not authorized. You have the right to seek care from any provider that is qualified to treat Medicare members. However, Original Medicare pays your claims and you must pay your cost-sharing.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 7, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services to get more information (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service, unless the plan offers, as a covered supplemental benefit, coverage beyond Original Medicare's limits. Any amounts you pay after the benefit has been exhausted will not count toward the out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you have already used.

SECTION 5. How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has not approved, you will be responsible for paying all costs for your participation in the study.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study and you have a full understanding and acceptance of what is involved if you participate in the study.

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

If you want to participate in a Medicare-approved clinical research study, you do not need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do not need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what we will pay.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

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

Original Medicare pays most of the cost of the covered services you receive as part of the study.

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

- Generally, Medicare will not pay for 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 and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (**https://www.medicare.gov**).

You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

SECTION 6. Rules for getting care covered in a "religious nonmedical health care institution"

Section 6.1 What is a religious nonmedical health care institution?

A religious nonmedical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious nonmedical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (nonmedical health care services). Medicare will only pay for nonmedical health care services provided by religious nonmedical health care institutions.

Section 6.2 What care from a religious nonmedical health care institution is covered by our plan?

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to nonreligious aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

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

SECTION 7. Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech-generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

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

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

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare before you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

CHAPTER 4. Medical Benefits Chart (what is covered and what you pay)

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

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of our plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services. In addition, please see Chapters 3, 9, and 10 for additional coverage information, including limitations (for example, coordination of benefits, durable medical equipment, home health care, skilled nursing facility care, and third party liability). Section 2.2 in this chapter describes our optional supplemental benefits, called Advantage Plus.

Also, be sure to read the Amendment titled "What You Need to Know – Your Important State-mandated Health Care Benefits and Rights and Other Legal Notices" for more information about your additional coverage.

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

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A "**copayment**" is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service, unless we do not collect all cost-sharing at that time and send you a bill later. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- "**Coinsurance**" is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service, unless we do not collect all cost-sharing at that time and send you a bill later. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Member Services.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

There is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B (see the Medical Benefits Chart in Section 2 below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of our plan, the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2020 is **$5,000** for High Option plan members and **6,700** for all other plan members. The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for

your plan premiums do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk (*) in the Medical Benefits Chart.

If you reach the maximum out-of-pocket amount of **$5,000** for High Option plan members and **$6,700** for all other members, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to "balance bill" you

As a member of our plan, an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. Here is how this protection works:

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends upon which type of provider you see:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, we cover services from out-of-network providers only in certain situations, such as when you get a referral.)
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for nonparticipating providers. (Remember, we cover services from out-of-network providers only in certain situations, such as when you get a referral.)
- If you believe a provider has "balance billed" you, call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 2. Use this Medical Benefits Chart to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of our plan

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

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) must be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered by our plan. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
  - If you get Medicare-covered services from an out-of-network provider and we do not cover the services, Original Medicare will cover the services. For any services covered by Original Medicare instead of our plan, you must pay Original Medicare's cost-sharing amounts.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in our plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart with a footnote (†). In addition, see Section 2.2 in this chapter and Chapter 3, Section 2.3, for more information about prior authorization, including other services that require prior authorization that are not listed in the Medical Benefits Chart.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay more in our plan than you would in Original Medicare. For others, you pay less. (If you want to know more about the coverage and costs of Original Medicare, look in your **Medicare & You** 2020 handbook. View it online at **https://www.medicare.gov** or ask for a copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing

medical condition during the visit when you receive the preventive service, cost-sharing will apply for the care received for the existing medical condition.

- Sometimes Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2020, either Medicare or our plan will cover those services.

 You will see this apple next to the preventive services in the Medical Benefits Chart.

Note: The Medical Benefits Chart below describes the following four Kaiser Permanente Medicare Plus plans:

- **High Option**.
- **Standard Option**.
- **Basic Option**.
- **Basic Part B Only Option**.

If you are not certain which plan you are enrolled in, please call Member Services or refer to the cover of your **Annual Notice of Changes**.

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
Abdominal aortic aneurysm screening† A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. • For **High Option or Standard Option** members, we also cover the services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) if you reasonably believe that you have an emergency medical condition and you reasonably believe that your condition requires the clinical support of ambulance transport services. • You may need to file a claim for reimbursement unless the provider agrees to bill us (see Chapter 5). • †Nonemergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	You pay the following **per one-way trip**, depending upon the plan in which you are enrolled: • **$200** for **High Option** plan members. • **$275** for **Standard Option** plan members. • **$375** for **Basic Option** or **Basic Part B Only Option** plan members
Annual routine physical exams for High Option and Standard Option plans Routine physical exams are covered if the exam is medically appropriate preventive care in accord with	There is no coinsurance, copayment, or deductible for this preventive care for **High Option** or **Standard Option** plan members.

† Your provider must obtain prior authorization from our plan.

* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
generally accepted professional standards of practice. This exam is covered once every 12 months. • **Not covered for Basic Option or Basic Part B Only Option plan members.**	
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement† For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39. • One screening mammogram every 12 months for women age 40 and older. • Clinical breast exams once every 24 months.	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services† Comprehensive programs for cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive	You pay the following **per visit**, depending upon the plan in which you are enrolled: • **$30** for **High Option** plan members.

† Your provider must obtain prior authorization from our plan.

* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	• **$45** for **Standard Option** plan members. • **$50** for **Basic Option** or **Basic Part B Only Option** plan members.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing† Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months. • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past three years: one Pap test every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services† Covered services include: • We cover only manual manipulation of the spine to correct subluxation.	You pay the following **per visit**, depending upon the plan in which you are enrolled: • **$5** for **High Option** plan members. • **$10** for **Standard Option** plan members.

† Your provider must obtain prior authorization from our plan.

* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
	• **$20** for **Basic Option** or **Basic Part B Only Option** plan members.
Colorectal cancer screening† • For people 50 and older, the following are covered: ♦ Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • One of the following every 12 months: ♦ Guaiac-based fecal occult blood test (gFOBT). ♦ Fecal immunochemical test (FIT). • DNA-based colorectal screening every 3 years. • For people at high risk of colorectal cancer, we cover a screening colonoscopy (or screening barium enema as an alternative) every 24 months. • For people not at high risk of colorectal cancer, we cover a screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.
Dental services for High and Standard plans*† • In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare. However, for **High Option** or **Standard Option** plan members, we cover preventive and comprehensive dental care when provided by a participating dental provider as described at the end of this chart under "Dental benefits and fee schedule for High Option or Standard Option plans" (please refer to that section for details about preventive and comprehensive dental coverage). • **Note:** You have additional dental coverage if you are enrolled in Advantage Plus, our optional supplemental benefits package. Please see Section 2.2 in this chapter for details. • **Not covered for Basic Option or Basic Part B Only Option plan members.**	Refer to "Dental benefits and fee schedule" at the end of the Medical Benefits Chart for cost-sharing information for **High Option** or **Standard Option** plan members.

† Your provider must obtain prior authorization from our plan.

* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
• **Accidental dental services:** Prompt repair, but not replacement, of sound natural teeth within one year of the accident, when services begin within 60 days of the injury and provided by a network provider. **Note**: Injuries incurred while eating or chewing are not covered.	You pay the following **per visit**, depending upon the plan in which you are enrolled: • **$30** for **High Option** plan members. • **$45** for **Standard Option** plan members. • **$50** for **Basic Option** or **Basic Part B Only Option** plan members.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training and diabetic services and supplies For all people who have diabetes (insulin and noninsulin users), covered services include: • †Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices, lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.	**No charge**
• †For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with	**20%** coinsurance

† Your provider must obtain prior authorization from our plan.

* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the noncustomized removable inserts provided with such shoes). Coverage includes fitting.	
• Diabetes self-management training is covered under certain conditions.	There is no coinsurance, copayment, or deductible for members eligible for the diabetes self-management training preventive benefit.
Durable medical equipment (DME) and related supplies† (For a definition of "durable medical equipment," see Chapter 10 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech-generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at **kp.org/directory**. You may also obtain any medically necessary DME from any supplier that contracts with fee-for-service Medicare (Original Medicare). However, if our plan does not contract with this supplier, you will have to pay the cost-sharing under fee-for-service Medicare.	**20%** coinsurance
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition.	**$90** per Emergency Department visit. This copayment does not apply if you are immediately admitted directly to the hospital as an inpatient (it does apply if you are admitted to the hospital as an

† Your provider must obtain prior authorization from our plan.

* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. • **High Option** and **Standard Option** plan members **have worldwide emergency care coverage.** • **Basic Option** and **Basic Part B Only Option** plan members have coverage while inside the United States and its territories.	outpatient; for example, if you are admitted for observation). †If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost-sharing you would pay at a network hospital.
Health and wellness education programs for High and Standard plans These programs focus on healthy lifestyles such as weight management, bladder control, and falls prevention, and clinical conditions such as diabetes, cholesterol, and pain management. Programs are designed to enrich the wellbeing of members through classes that are available at Kaiser Permanente medical centers and online classes. Other self-guided programs and tools are available online and include recipes, information on a variety of health topics, a health encyclopedia, a drug encyclopedia, videos, digital coaching, health calculators which help members check their progress to better health, walking, and weight control programs. Access to this information as well as online sign-up for classes available in your area can be found at **kp.org/healthyliving** after selecting your region.	• **No charge** for **High Option** or **Standard Option** plan members**.** • **Not covered** for **Basic Option** or **Basic Part B Only Option** plan members.
Hearing services† Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical	You pay the following **per visit**, depending upon the plan in which you are enrolled: • **$30** for **High Option** plan members.

† Your provider must obtain prior authorization from our plan.

* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. **Note:** Hearing aids are not covered unless you are enrolled in Advantage Plus as described in Section 2.2 of this chapter.	• **$45** for **Standard Option** plan members. • **$50** for **Basic Option** or **Basic Part B Only Option** plan members.
HIV screening • For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover one screening exam every 12 months. • For women who are pregnant, we cover up to three screening exams during a pregnancy.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care† Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services. To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week. • Physical therapy, occupational therapy, and speech therapy. • Medical and social services. • Medical equipment and supplies.	**No charge** **Note:** There is no cost-sharing for home health care services and items provided in accord with Medicare guidelines. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply if the item is covered under a different benefit; for example, durable medical equipment not provided by a home health agency.
Hospice care for members with Medicare Parts A and B 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	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, **not** our plan.

† Your provider must obtain prior authorization from our plan.

* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief. • Short-term respite care. • Home care. ***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 prognosis. 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 prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services. • *****If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare). **For any optional supplemental services that are covered by our plan:** 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 prognosis. You pay your plan cost-sharing amount for these services. **Note:** If you need nonhospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	
• We cover hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	You pay the following, depending upon the plan in which you are enrolled and the type of visit:

† Your provider must obtain prior authorization from our plan.

***** Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
	• **$5** per primary care visit and **$30** per specialty care visit for **High Option** plan members. • **$10** per primary care visit and $**45** per specialty care visit for **Standard Option** plan members. • **$35** per primary care visit and **$50** per specialty care visit for **Basic Option** plan members.
Hospice care for Basic Part B Only Option plan members • Our plan, rather than Original Medicare, covers hospice care for members who do not have Medicare Part A. Members must receive hospice services from network providers.	**No charge**
• We cover hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	**$35** per primary care visit and **$50** per specialty care visit.
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine. • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary. • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B. • Other vaccines if you are at risk and they meet Medicare Part B coverage rules.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.
In addition, we cover the following routine immunization endorsed by the Centers for Disease Control and Prevention (CDC) that is not covered by Medicare Part B: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under childhood immunizations).	**No charge**

† Your provider must obtain prior authorization from our plan.

* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care† Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. For **High Option** or **Standard Option** plan members, there is no limit to the number of medically necessary hospital days or services that are generally and customarily provided by acute care general hospitals. For **Basic Option** or **Basic Part B Only Option** plan members, we cover up to 90 days per benefit period. Covered services include, but are not limited to: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Costs of special care units (such as intensive care or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical, occupational, and speech language therapy. • Inpatient substance abuse services for medical management of withdrawal symptoms associated with substance abuse (detoxification). • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will	You pay the following **per benefit period**, depending upon the plan in which you are enrolled: • **$350** for **High Option** plan members (no charge for subsequent covered hospital stays within the same benefit period). • **$850** for **Standard Option** plan members (no charge for subsequent covered hospital stays within the same benefit period). • **$1,364** for up to 90 days per benefit period for **Basic Option** or **Basic Part B Only Option** plan members. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or skilled nursing facility (SNF). The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 calendar days in a row. †If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. **Note**: If a benefit period begins in 2019 for you and does not end until sometime in 2020, the 2019 cost-sharing will continue until the benefit period ends.

† Your provider must obtain prior authorization from our plan.

* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If we provide transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood—including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need. You must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Physician services.	
Note: To be an "inpatient," your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf** or by calling **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient mental health care† Covered services include mental health care services that require a hospital stay. • We cover up to 190 days per lifetime for inpatient stays in a Medicare-certified psychiatric hospital. The number of covered lifetime hospitalization days is reduced by the number of inpatient days for mental health treatment previously covered by Medicare in a psychiatric hospital.	You pay the following **per benefit period**, depending upon the plan in which you are enrolled: • **$350** for **High Option** plan members (no charge for subsequent covered hospital stays within the same benefit period).

† Your provider must obtain prior authorization from our plan.

* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
• The 190-day limit does not apply to mental health stays in a psychiatric unit of a general hospital. • For **Basic Option** or **Basic Part B Only Option** plan members, we cover up to 90 days per benefit period.	• **$850** for **Standard Option** plan members (no charge for subsequent covered hospital stays within the same benefit period). • **$1,364** for up to 90 days per benefit period for **Basic Option** or **Basic Part B Only Option** plan members. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or skilled nursing facility (SNF). The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 calendar days in a row. **Note**: If a benefit period begins in 2019 for you and does not end until sometime in 2020, the 2019 cost-sharing will continue until the benefit period ends.
Inpatient stay: Covered services received in a hospital or SNF during a noncovered inpatient stay† If you have exhausted your inpatient mental health or skilled nursing facility (SNF) benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient or SNF stay. However, in some cases, we will cover certain services you receive while you are in the hospital or SNF. Covered services include, but are not limited to: • Physician services.	Depending upon the plan in which you are enrolled, you pay the following for covered outpatient services and other items covered under Medicare Part B, when provided by network providers: • **$5** per primary care visit and **$30** per specialty care visit for **High Option** plan members. • **$10** per primary care visit and **$45** per specialty care visit for **Standard Option** plan members. • **$35** per primary care visit and **$50** per specialty care visit for **Basic Option** or **Basic Part B Only Option** plan members.

† Your provider must obtain prior authorization from our plan.

* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
• Physical therapy, speech therapy, and occupational therapy.	• **$30** per visit for **High Option** plan members. • **$40** per visit for all other members.
• Radium and isotope therapy, including technician materials and services.	• **$30** per visit for **High Option** plan members. • **$45** per visit for **Standard Option** plan members. • **$60** per visit for **Basic Option** or **Basic Part B Only Option** plan members.
• Diagnostic tests (like lab tests).	**No charge**
• X-rays.	• **$10** per visit for **High Option** plan members. • **$20** per visit for **Standard Option** plan members. • **$40** per visit for **Basic Option** or **Basic Part B Only Option** plan members.
• Surgical dressings. • Splints, casts, and other devices used to reduce fractures and dislocations. • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes (including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition).	**20%** coinsurance

† Your provider must obtain prior authorization from our plan.

* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Medical nutrition therapy† This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor. We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare health plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew his or her referral yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs† These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services. • Antigens. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents	**No charge**

† Your provider must obtain prior authorization from our plan.

* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
(such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa). • 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.	
• Drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan. • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant. • Certain oral anti-cancer drugs and anti-nausea drugs. • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases.	You pay the following for all other Medicare Part B prescription drugs, depending upon the plan you are enrolled, type of pharmacy, and drug: Network pharmacy located at a Kaiser Permanente facility or our mail-order pharmacy up to a 30-day supply: • **Generic drugs:** ♦ **$15** for **High Option** or **Standard Option** plan members. ♦ **$17** for **Basic Option** or **Basic Part B Only Option** plan members. • **Brand-name drugs**: ♦ **$42** for **High Option** plan members. ♦ **$45** for **Standard Option, Basic Option** or **Basic Part B Only Option** plan members. Network affiliated pharmacy up to a 30-day supply: • **Generic drugs:** ♦ **$20** for **High Option** or **Standard Option** plan members. ♦ **$34** for **Basic Option** or **Basic Part B Only Option** plan members.

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* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
	• **Brand-name drugs**: ♦ **$47** for **High Option** or **Standard Option** plan members. ♦ **$50** for **Basic Option** or **Basic Part B Only Option** plan members.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services† 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. Covered services include:	
• FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable.	**No charge** for clinically-administered Medicare Part B drugs when provided by an Opioid Treatment Program.
• Substance use counseling. • Individual and group therapy. • Toxicology testing.	You pay the following **per visit**, depending upon the plan in which you are enrolled: • **$30** for **High Option** plan members. • **$45** for **Standard Option** plan members. • **$50** for **Basic Option** or **Basic Part B Only Option** plan members.

† Your provider must obtain prior authorization from our plan.

* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies† Covered services include, but are not limited to: • Laboratory tests. • Electrocardiograms (EKGs) and electroencephalograms (EEGs). • Blood – including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need. You must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used.	**No charge**
• X-rays.	You pay the following **per visit**, depending upon the plan in which you are enrolled: • **$10** for **High Option** plan members. • **$20** for **Standard Option** plan members. • **$40** for **Basic Option** or **Basic Part B Only Option** plan members.
• Radiation (radium and isotope) therapy, including technician materials and supplies.	You pay the following **per visit**, depending upon the plan in which you are enrolled: • **$30** for **High Option** plan members. • **$45** for **Standard Option** plan members. • **$60** for **Basic Option** or **Basic Part B Only Option** plan members.
• Surgical supplies, such as dressings. • Splints, casts, and other devices used to reduce fractures and dislocations.	**20%** coinsurance

† Your provider must obtain prior authorization from our plan.

* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
• Other outpatient diagnostic tests. ♦ Magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), and nuclear medicine scans.	You pay the following per procedure, depending upon the plan in which you are enrolled: • **$100** for **High Option** plan members. • **$150** for **Standard Option** plan members. • **20% coinsurance** for **Basic Option** or **Basic Option Part B Only** plan members.
Outpatient hospital observation† Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf** or by calling **1-800-MEDICARE** (**1-800-633-4227**). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	When admitted directly to the hospital for observation as an outpatient, you pay the following **per stay**, depending upon the plan in which you are enrolled: • **$150** for **High Option** plan members. • **$250** for **Standard Option** plan members. • **$400** for **Basic Option** or **Basic Part B Only Option** plan members Note: There's no additional charge for outpatient observation stays when transferred for observation from an Emergency Department or outpatient surgery.

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* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services† We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an Emergency Department or outpatient clinic, such as observation services or outpatient surgery.	**Emergency Department** • **$90** per visit. **Outpatient surgery** You pay the following **per visit**, depending upon the plan in which you are enrolled: • **$150** for **High Option** plan members. • **$250** for **Standard Option** plan members. • **$400** for **Basic Option** or **Basic Part B Only Option** plan members. Refer to the "Outpatient hospital observation" section of this Medical Benefits Chart for the cost-sharing applicable to observation services.
• Laboratory and diagnostic tests billed by the hospital. • Certain drugs and biologicals that you can't give yourself. • X-rays and other radiology services billed by the hospital. • Medical supplies such as splints and casts.	**No additional charge** when received as part of the outpatient hospital visit.
• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it.	You pay the following **per day** for partial hospitalization, depending upon the plan in which you are enrolled: • **$5** for **High Optio**n plan members. • **$10** for **Standard Option** plan members. • **$55** for **Basic Option** or **Basic Part B Only Option** plan members.

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Services that are covered for you	What you must pay when you get these services
• Dental anesthesia and related hospital or ambulatory facility charges are covered when provided in conjunction with dental care to a member who is: ♦ seven years of age or younger or is developmentally disabled; and ♦ an individual for whom a successful result cannot be expected from care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition; and ♦ an individual for whom a superior result can be expected from dental care provided under general anesthesia; or ♦ an extremely uncooperative, fearful, or uncommunicative child who is 17 years of age or younger with dental needs of such magnitude that treatment should not be delayed or deferred; and ♦ an individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity; or ♦ an adult age 17 and older when the Member's medical condition (e.g., heart disease, hemophilia) requires that dental service be performed in a hospital or ambulatory surgical center for the safety of the member.	You pay the following **per visit** for outpatient surgery, depending upon the plan in which you are enrolled: • **$150** for **High Option** plan members. • **$250** for **Standard Option** plan members. • **$400** for **Basic Option** or **Basic Part B Only Option** plan members. **Note**: If the procedure results in a situation that requires hospitalization and you are admitted as an inpatient, the cost-sharing for inpatient care would also apply (see "Inpatient hospital care" section in this Medical Benefits Chart for cost-sharing information).
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	
Outpatient mental health care† Covered services include: • Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse	You pay the following, depending upon the plan in which you are enrolled and the type of visit: • **$5** per group therapy visit or **$10** per individual therapy visit

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* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	for **High Option plan** members. • **$10** per group therapy visit or **$20** per individual therapy visit for **Standard Option** plan members. • **$35** per group or individual therapy visit for **Basic Option** or **Basic Part B Only Option** plan members.
Outpatient rehabilitation services† • Covered services include physical therapy, occupational therapy, and speech language therapy. • Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	You pay the following **per visit**, depending upon the plan in which you are enrolled: • **$30** for **High Option** plan members. • **$40** for all other members.
Outpatient substance abuse services† Treatment for substance abuse is covered if medically necessary and reasonable for the patient's condition.	You pay the following depending upon the plan in which you are enrolled and the type of visit: • **$5** per group therapy visit or **$10** per individual therapy visit for **High Option** plan members. • **$10** per group therapy visit or **$20** per individual therapy visit for **Standard Option** plan members. • **$35** per group or individual therapy visit for **Basic Option** or **Basic Part B Only Option** plan members.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers†	You pay the following **per visit**, depending upon the plan in which you are enrolled:

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* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	• **$150** for **High Option** plan members. • **$250** for **Standard Option** plan members. • **$400** for **Basic Option** or **Basic Part B Only Option** plan members.
Partial hospitalization services† "Partial hospitalization" is a structured program of active psychiatric treatment, provided as a hospital outpatient service or by a community mental health center that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.	You pay the following **per day**, depending upon the plan in which you are enrolled: • **$5** for **High Option** plan members. • **$10** for **Standard Option** plan members. • **$55** for **Basic Option** or **Basic Part B Only Option** plan members.
Physician/practitioner services, including doctor's office visits Covered services include: • †Medically necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location. • †Consultation, diagnosis, and treatment by a specialist. • †Basic hearing and balance exams performed by a network provider, if your doctor orders it to see if you need medical treatment. • Second opinion by another network provider prior to surgery. • †Nonroutine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician).	**Office visits** You pay the following depending upon the plan in which you are enrolled and the type of visit: • **$5** per primary care visit and **$30** per specialty care visit for **High Option** plan members. • **$10** per primary care visit and **$45** per specialty care visit for **Standard Option** plan members. • **$35** per primary care visit and **$50** per specialty care visit for **Basic Option** or **Basic Part B Only Option** plan members. **Outpatient surgery** You pay the following **per visit**, depending upon the plan in which you are enrolled:

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Services that are covered for you	What you must pay when you get these services
	• **$150** for **High Option** plan members. • **$250** for **Standard Option** plan members. • **$400** for **Basic Option** or **Basic Part B Only Option** plan members.
• Telehealth services for monthly ESRD-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. • Brief virtual (for example, via telephone or video chat) 5- to 10-minute check-ins with your doctor, if you are an established patient and the virtual check-in is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment. • Remote evaluation of prerecorded video and/or images you send to your doctor, including your doctor's interpretation and follow-up within 24 hours (except weekends and holidays)—if you are an established patient and the remote evaluation is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment. • Consultation your doctor has with other physicians via telephone, internet, or electronic health record assessment—if you are an established patient. • All other telehealth services for **High Option** and **Standard Option** plan members, interactive video visits or scheduled telephone appointment visits for professional services when care can be provided in this format as determined by a network provider. Other telehealth services are not covered for either Basic plan members.	**No charge**

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* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Podiatry services† Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	**Office visits** You pay the following **per visit**, depending upon the plan in which you are enrolled: • **$30** for **High Option** plan members. • **$45** for **Standard Option** plan members. • **$50** for **Basic Option** or **Basic Part B Only Option** plan members. **Outpatient surgery** You pay the following **per visit**, depending upon the plan in which you are enrolled: • **$150** for **High Option** plan members. • **$250** for **Standard Option** plan members. • **$400** for **Basic Option** or **Basic Part B Only Option** plan members.
Prostate cancer screening exams For men age 50 and older, covered services include the following once every 12 months: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	There is no coinsurance, copayment, or deductible for an annual digital rectal exam or PSA test.
Prosthetic devices and related supplies† Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies	• **20%** coinsurance for external prosthetic or orthotic devices and supplies, including wound care supplies. • **No charge** for surgically implanted internal prosthetic devices.

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Services that are covered for you	What you must pay when you get these services
related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery (see "Vision care" later in this section for more detail).	
• For High or Standard plan members, certain custom-made compression bandages and garments not covered by Medicare. • **Not covered** for Basic Option or Basic Part B Only Option plan members.	**20%** coinsurance
Pulmonary rehabilitation services† Comprehensive programs for pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**$30** per visit.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low-dose computed tomography (LDCT)† For qualified individuals, a LDCT is covered every 12 months. • Eligible members are people aged 55–77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

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Services that are covered for you	What you must pay when you get these services
and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. • For LDCT lung cancer screenings after the initial LDCT screening, the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20- to 30-minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease† Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.	**No charge**
• Outpatient dialysis treatments.	**20%** coinsurance

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Services that are covered for you	What you must pay when you get these services
• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply).	
• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care).	No additional charge for services received during a hospital stay. Refer to the "Inpatient hospital care" section of this Medical Benefits Chart for the cost-sharing applicable to inpatient stays.
Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B drugs, please go to the section called "Medicare Part B prescription drugs."	
Skilled nursing facility (SNF) care† (For a definition of "skilled nursing facility care," see Chapter 10 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") We cover up to 100 days per benefit period of skilled inpatient services in a skilled nursing facility in accord with Medicare guidelines (a prior hospital stay is not required). Covered services include, but are not limited to: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Skilled nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood—including storage and administration. Coverage of whole blood and packed red cells begins	You pay the following **per benefit period**, depending upon the plan in which you are enrolled: • **No charge** for days 1–20. • **$110** per day for days 21–100 for **High Option** plan members. • **$160** per day for days 21–100 for **Standard Option** plan members. • **$170.50** per day for days 21–100 for **Basic Option** or **Basic Part B Only Option** plan members. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or skilled nursing facility (SNF). The benefit period ends when you haven't been an inpatient at any

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Services that are covered for you	What you must pay when you get these services
only with the fourth pint of blood that you need. You must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs. • Laboratory tests ordinarily provided by SNFs. • X-rays and other radiology services ordinarily provided by SNFs. • Use of appliances such as wheelchairs ordinarily provided by SNFs. • Physician/practitioner services.	hospital or SNF for 60 calendar days in a row. **Note**: If a benefit period begins in 2019 for you and does not end until sometime in 2020, the 2019 cost-sharing will continue until the benefit period ends.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) **If you use tobacco, but do not have signs or symptoms of tobacco-related disease:** We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. **If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:** We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Supervised Exercise Therapy (SET)† SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must:	**$30** per visit.

† Your provider must obtain prior authorization from our plan.

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Services that are covered for you	What you must pay when you get these services
• Consist of sessions lasting 30–60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication. • Be conducted in a hospital outpatient setting or a physician's office. • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD. • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques. **Note:** SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time, if deemed medically necessary by a health care provider.	
Urgently needed services Urgently needed services are provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. • **Inside our service area:** You must obtain urgent care from network providers, unless our provider network is temporarily unavailable or inaccessible due to an unusual and extraordinary circumstance (for example, major disaster). • **Outside our service area:** You have urgent care coverage when you travel if you need medical attention right away for an unforeseen illness or injury and you reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our service area. • **High Option** and **Standard Option** plan members have worldwide urgent care coverage.	**Office visits** You pay the following **per visit**, depending upon the plan in which you are enrolled: • **$30** for **High Option** plan members. • **$45** for **Standard Option** plan members. • **$65** for **Basic Option** or **Basic Part B Only Option** plan members. **Emergency Department** • **$90** per visit.

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Services that are covered for you	What you must pay when you get these services
• **Basic Option** and **Basic Part B Only Option** plan members have urgent care coverage while inside the United States and its territories. Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. See Chapter 3, Section 3, for more information.	
Vision care Covered services include: • †Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration.	You pay the following depending upon the plan in which you are enrolled: • **$5** per optometrist visit and **$30** per ophthalmologist care visit for **High Option** plan members. • **$10** per optometrist visit and **$45** per ophthalmologist visit for **Standard Option** plan members. • **$35** per optometrist visit and **$50** per ophthalmologist visit for **Basic Option** or **Basic Part B Only Option** plan members.
• †Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. However, for **High Option** and **Standard Option** plan members, we cover routine eye exams (eye refraction exams) to determine the need for vision correction and to provide a prescription for eyeglass lenses. • Routine eye exams are not covered for **Basic Option or Basic Part B Only Option** plan members.	You pay the following depending upon the plan in which you are enrolled: • **$5** per primary care visit and **$30** per specialty care visit for **High Option** plan members. • **$10** per primary care visit and **$45** per specialty care visit for **Standard Option** plan members.
• For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African-	**No charge**

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* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Americans who are age 50 and older, and Hispanic Americans who are 65 or older. • †For people with diabetes, screening for diabetic retinopathy is covered once per year.	
• †One pair of eyeglasses or contact lenses after each **cataract surgery** that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • †Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	**20%** coinsurance
***†Other eyewear for High Option or Standard Option plans:** • Once every calendar year, we provide a **$50** allowance for you to use toward the purchase price of eyewear from a plan optical facility when a physician or optometrist prescribes an eyeglass or contact lens for vision correction. The allowance can be used for the following items: ♦ Eyeglass lenses when a network provider puts the lenses into a frame. ♦ Eyeglass frames when a network provider puts two lenses (at least one of which must have refractive value) into the frame. ♦ Contact lenses, fitting, and dispensing. • We will not provide the allowance if we have provided an allowance toward (or otherwise covered) lenses or frames within the previous 12 months. • The allowance can only be used at the initial point of sale. If you do not use all of your allowance at the initial point of sale, you cannot use it later. **Note:** This allowance does not apply to eyewear obtained following cataract surgery.	If the eyewear you purchase costs more than **$50**, **you pay the difference**. **Note:** Your allowance is increased every 24 months if you are enrolled in Advantage Plus (see Section 2.2 in this chapter for details). • **Not covered** for **Basic Option** or **Basic Part B Only Option** plan members**.**

† Your provider must obtain prior authorization from our plan.

* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
"Welcome to Medicare" preventive visit We cover the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.
Note: Refer to Chapter 1 (Section 8) and Chapter 9 for information about coordination of benefits that applies to all covered services described in this Medical Benefits Chart.	

† Your provider must obtain prior authorization from our plan.

• Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

Dental benefits and fee schedule for High or Standard Option plans*

Note: Dental benefits are not covered for Basic Option or Basic Part B Only Option plan members.

General terms and conditions

- Subject to the terms, conditions, limitations, and exclusions specified in this **Evidence of Coverage** including Chapter 8, "Definitions of Important Words," you may receive covered dental services from participating dental providers.
- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. has entered into an agreement with Dental Administrator to provide covered dental services through participating dental providers.
- Only the dental procedures listed in the dental fee schedule below are covered dental services. When you receive any of the listed procedures from a participating dental provider, you will pay the fee listed for that service. The participating dental provider has agreed to accept that fee as payment in full for that procedure. Neither Kaiser Permanente nor Dental Administrator is liable for payment of these fees or for any fees incurred as the result of receipt of a noncovered dental service.
- You will receive a list of participating dental providers from the Health Plan or Dental Administrator. You should select a participating dental provider "general dentist" from whom you and your family members will receive covered preventive dental services and other covered dental services. Family members may use different participating dental providers. Specialty care is also available should that be required; however, you must be referred to a participating dental provider specialist by your general dentist. Your fees are usually higher for care received by a specialist. Please refer to the attached dental fee schedule for those discounted fees.
- You may obtain a list of participating dental providers by contacting Dental Administrator at the numbers listed below or our Member Services Department at **1-888-777-5536** (TTY **711**). Seven days a week, 8 a.m. to 8 p.m.
- Dental Administrator (DOMINION NATIONAL): Health Plan has entered into an agreement with DOMINION NATIONAL to provide covered dental services as described in this section. For assistance concerning dental coverage questions, or for help finding a participating dental provider, DOMINION Member Services specialists are available Monday through Friday from 7:30 a.m. to 6 p.m. by calling **1-855-733-7524** (TTY users call **711**).
- DOMINION's Integrated Voice Response System is available 24 hours a day for information about participating dental providers in your area, or to help you select a participating dental provider. The most up-to-date list of participating dental providers can be found at the following website: www.dominiondentalnational.com/Kaiserdentists.
- DOMINION also provides many other secure features online at **www.dominionnational.com**.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.
†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

Dental emergencies outside the service area

When a dental emergency occurs outside the service area, Dental Administrator will reimburse you for the reasonable charges for covered dental services that may be provided, less any discounted fee, upon proof of payment, not to exceed $50 per incident. Coverage is provided for emergency dental treatment as may be required to alleviate pain, bleeding, or swelling. You must receive all post-emergency care from a participating dental provider.

Discounted schedule of fees $30 preventive plan

Procedures not shown in this list are not covered. Refer to the description of your dental benefit for a complete description of the terms and conditions of your covered benefit.

Fees quoted in the "What you must pay Dentist" column apply only when performed by a participating general dentist. If specialty care is required, your general dentist must refer you to a participating specialist.

FC $30: You pay a combined fixed copayment of $30 for any visit during which one or more of the following procedures are performed: (a) an oral exam (D0120, D0140, D0150, D0170 or D0180); (b) X-rays (D0220, D0230, D0240, D0250, D0270, D0272, D0273, D0274, D0277, D0340, D0350 or D0351); (c) a pulp vitality test (D0460); (d) a diagnostic cast (D0470); (e) a routine cleaning (D1110); (f) fluoride application (D1206 or D1208); or (g) you are given oral hygiene instructions (D1310, D1320 or D1330). You pay a separate fee for any other procedure performed.

Coverage for periodic oral exams and prophylaxes (cleanings) is limited to two times per calendar year. Fluoride applications is limited to once a calendar year.

ADA Code	Description of Services for High or Standard Option plans	*What you must pay	
		Dentist	Specialist
Diagnostic Services†			
D0120	Periodic oral evaluation (two per calendar year)	FC $30	Not covered
D0140	Limited oral evaluation - problem focused	FC $30	Not covered
D0150	Comprehensive oral evaluation - new or established patient	FC $30	Not covered
D0170	Re-evaluation - limited, problem focused	FC $30	Not covered
D0180	Comprehensive periodontal evaluation - new or established patient - not in conjunction with D0150 and limited to once per 18 months	FC $30	Not covered
D0210	Intraoral - complete series of radiographic images	$54	$69
D0220	Intraoral - periapical first radiographic image	FC $30	$14

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†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Description of Services for High or Standard Option plans	*What you must pay	
		Dentist	Specialist
D0230	Intraoral - periapical each additional radiographic image	FC $30	$11
D0240	Intraoral - occlusal radiographic image	FC $30	$21
D0250	Extraoral - 2D projection radiographic image	FC $30	$26
D0270	Bitewing - single radiographic image	FC $30	$14
D0272	Bitewings - two radiographic images	FC $30	$21
D0273	Bitewings - three radiographic images	FC $30	$28
D0274	Bitewings - four radiographic images	FC $30	$31
D0277	Vertical bitewings - 7 to 8 radiographic images	FC $30	$47
D0330	Panoramic radiographic image	$43	$55
D0340	2D cephalometric radiographic image	FC $30	$55
D0350	2D oral/facial photographic images	FC $30	$29
D0351	3D photographic image	FC $30	$32
D0460	Pulp vitality tests	FC $30	$35
D0470	Diagnostic casts (not in conjunction with Orthodontics)	FC $30	Not covered
Preventive Services			
D1110	Prophylaxis (cleaning) - adult	FC $30	Not covered
D1110	Additional cleaning – beyond benefit limitation	$40	$40
D1206	Topical fluoride varnish for moderate/high risk caries patients	FC $30	Not covered
D1208	Topical application of fluoride – excluding varnish	FC $30	Not covered
D1310	Nutritional counseling for control of dental disease	FC $30	Not covered
D1320	Tobacco counseling for control and prev. of oral disease	FC $30	Not covered
D1330	Oral hygiene instructions	FC $30	Not covered
D1352	Prev resin rest. mod/high caries risk – perm. tooth	$30	Not covered
Restorative Services†			
D2140	Amalgam - one surface, primary or permanent	$68	Not covered
D2150	Amalgam - two surfaces, primary or permanent	$88	Not covered
D2160	Amalgam - three surfaces, primary or permanent	$105	Not covered
D2161	Amalgam - four or more surfaces, primary or permanent	$126	Not covered
D2330	Resin-based composite - one surface, anterior	$83	Not covered

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Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Description of Services for High or Standard Option plans	*What you must pay	
		Dentist	Specialist
D2331	Resin-based composite - two surfaces, anterior	$105	Not covered
D2332	Resin-based composite - three surfaces, anterior	$129	Not covered
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$163	Not covered
D2390	Resin-based composite crown, anterior	$216	Not covered
D2391	Resin-based composite - one surface, posterior	$108	Not covered
D2392	Resin-based composite - two surfaces, posterior	$143	Not covered
D2393	Resin-based composite - three surfaces, posterior	$179	Not covered
D2394	Resin-based composite - four or more surfaces, posterior	$204	Not covered
D2510	Inlay - metallic - one surface	$493	Not covered
D2520	Inlay - metallic - two surfaces	$556	Not covered
D2530	Inlay - metallic - three or more surfaces	$604	Not covered
D2542	Onlay – metallic - two surfaces	$641	Not covered
D2543	Onlay – metallic - three surfaces	$653	Not covered
D2544	Onlay – metallic – 4 or more surfaces	$657	Not covered
D2610	Inlay - porcelain/ceramic - one surface	$541	Not covered
D2620	Inlay - porcelain/ceramic - two surfaces	$576	Not covered
D2630	Inlay - porcelain/ceramic - three or more surfaces	$665	Not covered
D2642	Onlay - porcelain/ceramic - two surfaces	$616	Not covered
D2643	Onlay - porcelain/ceramic - three surfaces	$666	Not covered
D2644	Onlay – porcelain/ceramic - 4 or more surfaces	$710	Not covered
D2650	Inlay - resin-based composite - one surface	$498	Not covered
D2651	Inlay - resin-based composite - two surfaces	$538	Not covered
D2652	Inlay - resin-based composite - three or more surfaces	$699	Not covered
D2662	Onlay - resin-based composite - two surfaces	$568	Not covered
D2663	Onlay - resin-based composite - three surfaces	$699	Not covered
D2664	Onlay - resin-based composite - >=4 surfaces	$662	Not covered
D2710	Crown - resin (indirect)	$277	Not covered
D2712	Crown 3/4 resin-based composite (exclusive of veneers)	$450	Not covered
D2720	Crown - resin with high noble metal	$675	Not covered

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†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Description of Services for High or Standard Option plans	*What you must pay	
		Dentist	Specialist
D2721	Crown - resin with predominantly base metal	$601	Not covered
D2722	Crown - resin with noble metal	$628	Not covered
D2740	Crown - porcelain/ceramic	$741	Not covered
D2750	Crown - porcelain fused to high noble metal	$755	Not covered
D2751	Crown - porcelain fused to predominantly base metal	$653	Not covered
D2752	Crown - porcelain fused to noble metal	$679	Not covered
D2780	Crown - 3/4 cast high noble metal	$724	Not covered
D2781	Crown - 3/4 cast predominantly base metal	$566	Not covered
D2782	Crown - 3/4 cast noble metal	$611	Not covered
D2783	Crown - 3/4 porcelain/ceramic	$628	Not covered
D2790	Crown - full cast high noble metal	$675	Not covered
D2791	Crown - full cast predominantly base metal	$601	Not covered
D2792	Crown - full cast noble metal	$628	Not covered
D2794	Crown - titanium	$679	Not covered
D2910	Recement inlay	$68	Not covered
D2920	Recement crown	$68	Not covered
D2932	Prefabricated resin crown	$254	Not covered
D2940	Protective restoration	$77	Not covered
D2950	Core buildup, including any pins	$172	Not covered
D2951	Pin retention - per tooth, in addition to restoration	$40	Not covered
D2952	Post and core in addition to crown	$252	Not covered
D2954	Prefabricated post and core in addition to crown	$224	Not covered
D2955	Post removal (not in conj. with endo. therapy)	$194	Not covered
D2980	Crown repair necessitated by restorative material failure	$138	Not covered
D2981	Inlay repair necessitated by restorative material failure	$138	Not covered
D2982	Onlay repair necessitated by restorative material failure	$138	Not covered
Endodontic Services†			
D3110	Pulp cap - direct (excluding final restoration)	$47	Not covered
D3120	Pulp cap - indirect (excluding final restoration)	$47	Not covered

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Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Description of Services for High or Standard Option plans	*What you must pay	
		Dentist	Specialist
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$104	$122
D3221	Pulpal debridement, prim. and perm. teeth	$126	Not covered
D3310	Endodontic therapy, anterior (excluding final restoration)	$482	$554
D3320	Endodontic therapy, premolar (excluding final restoration)	$576	$663
D3330	Endodontic therapy, molar (excluding final restoration)	$755	$867
D3333	Internal root repair of perforation defects	Not covered	$225
D3346	Retreatment of previous root canal therapy - anterior	Not covered	$609
D3347	Retreatment of previous root canal therapy - premolar	Not covered	$812
D3348	Retreatment of previous root canal therapy - molar	Not covered	$1,047
D3410	Apicoectomy - anterior	$422	$524
D3421	Apicoectomy- premolar (first root)	$471	$655
D3425	Apicoectomy - molar (first root)	$518	$687
D3426	Apicoectomy (each additional root)	$314	$371
D3427	Periradicular surg. w/o apicoectomy	$402	$504
D3430	Retrograde filling - per root	$118	$295
D3450	Root amputation - per root	$205	$330
D3920	Hemisection (including any root removal), not including root canal therapy	$258	$305
D3950	Canal prep/fitting of preformed dowel or post	$154	$216
Periodontic Services†			
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth per quadrant	$372	$439
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant	$161	$190
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth	$479	$566
D4241	Gingival flap procedure, including root planing - one to three teeth, per quadrant	$121	$239
D4260	Osseous surgery (including flap entry and closure) - four or more per quadrant	$709	$836

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Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Description of Services for High or Standard Option plans	*What you must pay	
		Dentist	Specialist
D4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant	$452	$534
D4268	Surgical revision procedure, per tooth	$389	$562
D4274	Mesial/distal wedge procedure, single tooth	$329	$466
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$137	$194
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	$99	$117
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$76	$103
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$121	$175
D4381	Localized delivery of chemotherapeutic agents	$90	$101
D4910	Periodontal maintenance	$83	$110
Prosthetics - Removable†			
D5110	Complete denture - maxillary	$845	Not covered
D5120	Complete denture - mandibular	$845	Not covered
D5130	Immediate denture - maxillary	$910	Not covered
D5140	Immediate denture - mandibular	$910	Not covered
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$653	Not covered
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$653	Not covered
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$906	Not covered
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$906	Not covered
D5221	Immediate maxillary partial denture	$653	Not covered
D5222	Immediate mandibular partial denture	$653	Not covered
D5223	Immediate maxillary partial denture	$906	Not covered

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Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Description of Services for High or Standard Option plans	*What you must pay	
		Dentist	Specialist
D5224	Immediate mandibular partial denture	$906	Not covered
D5225	Maxillary partial denture	$904	Not covered
D5226	Mandibular partial denture	$1,004	Not covered
D5282	Removable unilateral partial denture - one piece cast metal, maxillary	$510	Not covered
D5283	Removable unilateral partial denture - one piece cast metal, mandibular	$510	Not covered
D5410	Adjust complete denture - maxillary	$79	Not covered
D5411	Adjust complete denture - mandibular	$79	Not covered
D5421	Adjust partial denture - maxillary	$79	Not covered
D5422	Adjust partial denture - mandibular	$79	Not covered
D5511	Repair broken complete denture base - mandibular	$101	Not covered
D5512	Repair broken complete denture base - maxillary	$101	Not covered
D5520	Replace missing or broken teeth - complete denture (each tooth)	$84	Not covered
D5611	Repair resin denture base - mandibular	$102	Not covered
D5612	Repair resin denture base - maxillary	$102	Not covered
D5621	Repair cast partial framework - mandibular	$147	Not covered
D5622	Repair cast partial framework - maxillary	$147	Not covered
D5630	Repair or replace broken retentive/clasping material – per tooth	$139	Not covered
D5640	Replace broken teeth - per tooth	$88	Not covered
D5650	Add tooth to existing partial denture	$131	Not covered
D5660	Add clasp to existing partial denture – per tooth	$160	Not covered
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$559	Not covered
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$559	Not covered
D5710	Rebase complete maxillary denture	$344	Not covered
D5711	Rebase complete mandibular denture	$331	Not covered
D5720	Rebase maxillary partial denture	$265	Not covered
D5721	Rebase mandibular partial denture	$265	Not covered

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†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Description of Services for High or Standard Option plans	*What you must pay	
		Dentist	Specialist
D5730	Reline complete maxillary denture (chairside)	$214	Not covered
D5731	Reline complete mandibular denture (chairside)	$215	Not covered
D5740	Reline maxillary partial denture (chairside)	$212	Not covered
D5741	Reline mandibular partial denture (chairside)	$212	Not covered
D5750	Reline complete maxillary denture (laboratory)	$260	Not covered
D5751	Reline complete mandibular denture (laboratory)	$258	Not covered
D5760	Reline maxillary partial denture (laboratory)	$250	Not covered
D5761	Reline mandibular partial denture (laboratory)	$249	Not covered
D5810	Interim complete denture (maxillary)	$549	Not covered
D5811	Interim complete denture (mandibular)	$400	Not covered
D5820	Interim partial denture (maxillary)	$424	Not covered
D5821	Interim partial denture (mandibular)	$429	Not covered
D5850	Tissue conditioning, maxillary	$120	Not covered
D5851	Tissue conditioning, mandibular	$121	Not covered
Prosthetics - Fixed†			
D6000-D6199	ALL IMPLANT SERVICES - 15% DISCOUNT (incl. D0360-D0363 cone beam imaging w/ implants)		
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$99	$117
D6210	Pontic - cast high noble metal	$610	Not covered
D6211	Pontic - cast predominantly base metal	$624	Not covered
D6212	Pontic - cast noble metal	$586	Not covered
D6214	Pontic - titanium	$571	Not covered
D6240	Pontic - porcelain fused to high noble metal	$755	Not covered
D6241	Pontic - porcelain fused to predominantly base metal	$653	Not covered
D6242	Pontic - porcelain fused to noble metal	$679	Not covered
D6245	Pontic – porcelain/ceramic	$741	Not covered
D6250	Pontic - resin with high noble metal	$745	Not covered
D6251	Pontic - resin with predominantly base metal	$707	Not covered
D6252	Pontic - resin with noble metal	$717	Not covered

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Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Description of Services for High or Standard Option plans	*What you must pay	
		Dentist	Specialist
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$270	Not covered
D6548	Retainer. - porcelain/ceramic for resin bonded fixed prosthesis	$481	Not covered
D6549	Resin retainer – for resin bonded fixed prosthesis	$270	Not covered
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$410	Not covered
D6601	Retainer inlay - porcelain/ceramic, >=3 surfaces	$426	Not covered
D6602	Retainer inlay - cast high noble metal, two surfaces	$422	Not covered
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$468	Not covered
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$422	Not covered
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$407	Not covered
D6606	Retainer inlay - cast noble metal, two surfaces	$384	Not covered
D6607	Retainer inlay - cast noble metal, three or more surfaces	$426	Not covered
D6608	Retainer onlay -porcelain./ceramic, two surfaces	$439	Not covered
D6609	Retainer onlay - porcelain./ceramic, three or more surfaces	$459	Not covered
D6610	Retainer onlay - cast high noble metal, two surfaces	$501	Not covered
D6611	Retainer onlay cast high noble metal >=3 surfaces	$548	Not covered
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$431	Not covered
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$511	Not covered
D6614	Retainer onlay - cast noble metal, two surfaces	$454	Not covered
D6615	Retainer onlay cast noble metal >=3 surfaces	$511	Not covered
D6624	Retainer inlay - titanium	$468	Not covered
D6634	Retainer onlay - titanium	$548	Not covered
D6720	Retainer crown - resin with high noble metal	$747	Not covered
D6721	Retainer crown - resin with predominantly base metal	$666	Not covered
D6722	Retainer crown - resin with noble metal	$696	Not covered
D6740	Retainer crown – Porcelain/ceramic	$741	Not covered
D6750	Retainer crown - porcelain fused to high noble metal	$639	Not covered

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Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Description of Services for High or Standard Option plans	*What you must pay	
		Dentist	Specialist
D6751	Retainer crown - porcelain fused to predominantly base metal	$571	Not covered
D6752	Retainer crown - porcelain fused to noble metal	$599	Not covered
D6780	Retainer crown - 3/4 cast high noble metal	$724	Not covered
D6781	Retainer crown - 3/4 cast predominantly base metal	$566	Not covered
D6782	Retainer crown - 3/4 cast noble metal	$578	Not covered
D6783	Retainer crown - 3/4 porc./ceramic	$808	Not covered
D6790	Retainer crown - full cast high noble metal	$675	Not covered
D6791	Retainer crown - full cast predominantly base metal	$601	Not covered
D6792	Retainer crown - full cast noble metal	$628	Not covered
D6794	Retainer crown - titanium	$679	Not covered
D6930	Recement or rebond fixed partial denture	$88	Not covered
D6940	Stress breaker	$205	Not covered
D6980	Fixed partial denture repair, by report	$206	Not covered
Oral Surgery†			
D7111	Extraction, coronal remnants - primary tooth	$72	$85
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$83	$97
D7210	Extraction of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$149	$176
D7220	Removal of impacted tooth - soft tissue	$183	$216
D7230	Removal of impacted tooth - partially bony	$250	$295
D7240	Removal of impacted tooth - completely bony	$295	$347
D7241	Removal of impacted tooth - completely bony, with unusual surg. complications	$363	$429
D7250	Removal of residual tooth roots (cutting procedure)	$167	$199
D7251	Coronectomy - intentional partial tooth removal	$363	$429
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$279	$330
D7280	Exposure of an unerupted tooth	$312	$369
D7282	Mobiliz. of erupted or malpos. tooth-aid erup	$96	$210

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.
†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Description of Services for High or Standard Option plans	*What you must pay	
		Dentist	Specialist
D7285	Biopsy of oral tissue - hard (bone, tooth)	$196	$231
D7286	Biopsy of oral tissue - soft (all others)	$184	$216
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$142	$169
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$150	$177
D7311	Alveoloplasty in conjunction with extractions	$130	$154
D7320	Alveoloplasty not in conjunction with extractions – per quadrant	$193	$227
D7321	Alveoloplasty not in conjunction with extractions	$40	$84
D7471	Removal of lateral exostosis	$314	$370
D7472	Removal of torus palatinus	$263	$311
D7473	Removal of torus mandibularis	$271	$320
D7485	Reduction of osseous tuberosity	$297	$351
D7510	Incision and drainage of abscess - intraoral soft tissue	$108	$127
D7511	Incision and drainage of abscess - intraoral	$226	$260
D7910	Suture of recent small wounds up to 5 cm	$246	$290
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$226	$314
D7963	Frenuloplasty	$99	$245
D7970	Excision of hyperplastic tissue - per arch	$456	$539
D7971	Excision of pericoronal gingiva	$225	$265
D7972	Surgical reduction of fibrous tuberosity	$78	$185
D7979	Non-surgical sialolithotomy	$43	$88
Orthodontics†			
D8090	Comprehensive orthodontic treatment of the adult dentition	Not covered	$3,658
D8660	Pre-orthodontic treatment visit	Not covered	$413
D8670	Periodic orthodontic treatment visit (as part of contract)	Not covered	$118
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	Not covered	$516
Additional Procedures†			
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$43	$88

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.
†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Description of Services for High or Standard Option plans	*What you must pay	
		Dentist	Specialist
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0	Not covered
D9211	Regional block anesthesia	$0	Not covered
D9212	Trigeminal division block anesthesia	$0	Not covered
D9215	Local anesthesia	$0	Not covered
D9219	Evaluation for deep sedation or general anesthesia	$0	Not covered
D9222	Deep sedation/general anesth – first 15 minute increment	$103	$178
D9223	Deep sedation/general anesth – each subsequent 15 minute increment	$103	$178
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$37	$42
D9239	Intrav moderate sedation/analgesia – first 15 minute increment	$103	$178
D9243	Intrav moderate sedation/analgesia – each subsequent 15 minute increment	$103	$178
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$59	$96
D9439	Office visit - Not including an FC30 visit	$10	$10
D9440	Office visit - after regularly scheduled hours	$27	$111
D9613	Infiltration of sustained release therapeutic drug – single or multiple sites	$190	$190
D9910	Application of desensitizing medicament	$31	$61
D9930	Treatment of complications (post-surgical)	$48	$48
D9944	Occlusal guard – hard appliance, full arch	$338	$519
D9945	Occlusal guard – soft appliance, full arch	$338	$519
D9946	Occlusal guard – hard appliance, partial arch	$338	$519
D9950	Occlusion analysis - mounted case	$169	$169
D9951	Occlusal adjustment - limited	$88	$115
D9952	Occlusal adjustment - complete	$372	$597
D9986	Missed appointment	$50	$50
D9995	Teledentistry – synchronous; real-time encounter	$20	$20
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	$20	$20

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.
†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

Section 2.2 Extra "optional supplemental" benefits you can buy if you are a High or Standard plan member

Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package as a plan member. These extra benefits are called "optional supplemental benefits." If you want these optional supplemental benefits, you must sign up for the benefit and you will have to pay an additional premium for it. If you fail to pay the additional premium, the benefit may be terminated. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits.

The optional supplemental benefits package offered by our plan is called "Advantage Plus." You only receive the hearing aid, additional dental, and additional eyewear benefits described in this section if you are enrolled in Advantage Plus. Please note that you cannot purchase just one of these benefits—they are offered together as a total package and are not available individually. **Note: Advantage Plus is only available to members of the High Option and Standard Option plans.**

When you can enroll in Advantage Plus

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

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

Disenrollment from Advantage Plus

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

If you disenroll from Advantage Plus and want to join in the future, please see "When you can enroll in Advantage Plus" above for the times when you can enroll. Please keep in mind that your hearing aid and eyewear benefits will not renew upon reenrollment because hearing aids are provided once every 36 months and eyewear is provided once every 24 months.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.
†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

Advantage Plus – *These optional supplemental benefits only apply to members enrolled in Advantage Plus.*	**What you must pay***
Additional monthly premium This additional monthly premium is added to your Kaiser Permanente Medicare Advantage monthly plan premium (see Chapter 1, Section 4.1, for more premium information).	**$25**
Additional eyewear coverage† • If you are enrolled in Advantage Plus, your eyewear benefit is increased by giving you a **$175** allowance to help pay for eyewear. Every 24 months, the allowance can be used to reduce what you pay for eyewear. $175 is subtracted from your balance owing after your standard eyewear benefits have been applied (see "Vision care" in the Medical Benefits Chart for details about your standard eyewear benefits). • We will not provide the allowance if we have provided an Advantage Plus eyewear allowance within 24 months. • 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. • Eyewear must be purchased at a network optical facility and prescribed by a network physician or optometrist for vision correction. • **Note:** This allowance does not apply to eyewear obtained following cataract surgery.	If the eyewear you purchase costs more than $175, **you pay the difference**.
Hearing aid coverage† If you are enrolled in Advantage Plus, we cover the hearing aid services listed below when prescribed by a network provider (clinical audiologist). We select the provider or vendor that will furnish the covered hearing aid. Coverage is limited to the types and models of hearing aids furnished by the provider or vendor. We cover the following: • An allowance of up to **$1,000 per hearing aid, per ear** that you can use toward the purchase of one hearing aid every 36 months. If two aids are required to provide significant improvement that is not obtainable with only one hearing aid, we will cover one hearing aid for each ear. The $1,000 allowance per ear may only be used once in any 36-month period. If you do not use all of the $1,000 at the initial point of sale, you cannot use it later. We also cover the following: ♦ Hearing tests to determine the appropriate hearing aid(s). ♦ Visits to verify that the hearing aid(s) conforms to the prescription.	If the hearing aid you purchase costs more than $1,000, **you pay the difference**.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.
†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

Advantage Plus – *These optional supplemental benefits only apply to members enrolled in Advantage Plus.*	**What you must pay***
♦ Visits for fitting, counseling, adjustment, cleaning, and inspection after the warranty is exhausted.	

Advantage Plus DHMO dental benefits

Subject to the terms, conditions, limitations, and exclusions specified in this Evidence of Coverage including Chapter 10, "Definitions of Important Words," you may receive covered dental services from participating dental providers. See Section 3 of this chapter for dental exclusions and limitations.

Services received from non-participating dentists are not covered under this plan except for benefits provided under a referral to a non-participating dental provider and dental emergencies.

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

For some services, you will be required to pay a combined fixed copayment for all such services provided during each visit. Please refer to the following list of Covered Procedures for details. You will pay copayments for certain other Covered Dental Services you receive from Participating Dental Providers. You will pay the applicable copayment directly to the Participating Dental Provider at the time services are rendered. Only the dental procedures listed in this dental fee schedule below are covered dental services. The participating dental provider has agreed to accept your copayment as payment in full of your responsibility for that procedure. Neither Kaiser Permanente nor Dental Administrator is liable for payment of these fees or for any fees incurred as the result of receipt of a non-covered dental service.

You will receive a list of participating dental providers from the Health Plan or Dental Administrator. You should select a participating dental provider "general dentist" from whom you and your family members will receive covered preventive dental services and other covered dental services. Family members may use different participating dental providers. Specialty care is also available should it be required; referrals are strongly encouraged so as to assist with communications between your participating general dentists and the participating dental provider specialist and are subject to exclusions and limitations described in Section 3 of this chapter.

You may obtain a list of participating dental providers by calling:

- Member Services at **1-888-777-5536** (TTY **711**). Seven days a week, 8 a.m. to 8 p.m.
- For questions about dental coverage or for help finding a participating dental provider, call Member Services at the Dental Administrator (DOMINION NATIONAL) at **1-855-733-7524**, Monday through Friday from 7:30 a.m. to 6 p.m. TTY users call **711**.

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.
†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

Advantage Plus – *These optional supplemental benefits only apply to members enrolled in Advantage Plus.*	**What you must pay***

- DOMINION's Integrated Voice Response System is available 24 hours a day for information about participating dental providers in your area, or to help you select a participating dental provider. The most up-to-date list of participating dental providers can be found at the following website: **www.dominionnational.com/Kaiserdentists**.
- DOMINION also provides many other secure features online at **www.dominionnational.com**.

Dental emergencies outside the service area
If you are more than 50 miles from your Participating Dentist, you may have emergency services rendered by any licensed dentist. Emergency services is defined as "palliative care of injury, toothache, or accident requiring the immediate attention of a dentist." Plan reimburses for emergency out-of-area services up to **$100** per incident. Services are limited to those procedures not excluded under plan limitations and exclusions. You must receive all post-emergency care from your Participating Dentist.

DHMO description of benefits and your copayments
Procedures not shown in the chart below are not covered. Refer to the description of your dental benefit for a complete description of the terms and conditions of your covered benefit. Also, see Section 3 in this chapter for the services and items that are excluded and limited. Exclusions and limitations are not listed in this chart.

The copayment listed in the "What you must pay" column applies only when performed by your participating general dentist. You must select a Participating Dentist and get your dental care from that dentist except as otherwise noted. If specialty care is required, your general dentist must refer you to a participating dental provider specialist.

ADA Code	Advantage Plus covered dental services	*What you must pay
Diagnostic Services		
D9439	Office visit	$10
D0120	Periodic oral evaluation	$0
D0140	Limited oral evaluation - problem focused	$0
D0150	Comprehensive oral evaluation - new or established patient	$0

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.
†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Advantage Plus covered dental services	*What you must pay
D0160	Detailed and extensive evaluation - problem focused	$0
D0170	Re-evaluation - limited, problem focused	$0
D0180	Comprehensive periodontal evaluation - new or established patient - not in conjunction with D0150 and limited to once per 18 months	$36
D0210	Intraoral - complete series of radiographic images	$26
D0220	Intraoral - periapical first radiographic image	$0
D0230	Intraoral - periapical each additional radiographic image	$0
D0240	Intraoral - occlusal radiographic image	$0
D0250	Extraoral - 2D projection radiographic image	$0
D0270	Bitewing - single radiographic image	$0
D0272	Bitewings - two radiographic images	$0
D0273	Bitewings - three radiographic images	$0
D0274	Bitewings - four radiographic images	$0
D0277	Vertical bitewings - 7 to 8 radiographic images	$0
D0330	Panoramic radiographic image	$30
D0340	2D cephalometric radiographic image	$0
D0350	2D oral/facial photographic images	$0
D0351	3D photographic image	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts (not in conjunction with Orthodontics)	$0
Preventive Services		
D1110	Prophylaxis (cleaning) - adult	$0
D1110	Additional cleaning – expecting mothers or diabetics	$40
D1206	Topical fluoride varnish for moderate/high risk caries patients	$0
D1208	Topical application of fluoride	$0
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
Restorative Services		
D2140	Amalgam - one surface, primary or permanent	$37

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.
†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Advantage Plus covered dental services	*What you must pay
D2150	Amalgam - two surfaces, primary or permanent	$46
D2160	Amalgam - three surfaces, primary or permanent	$58
D2161	Amalgam - four or more surfaces, primary or permanent	$69
D2330	Resin-based composite - one surface, anterior	$64
D2331	Resin-based composite - two surfaces, anterior	$76
D2332	Resin-based composite - three surfaces, anterior	$90
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$109
D2390	Resin-based composite crown, anterior	$175
D2391	Resin-based composite - one surface, posterior	$68
D2392	Resin-based composite - two surfaces, posterior	$80
D2393	Resin-based composite - three surfaces, posterior	$93
D2394	Resin-based composite - four or more surfaces, posterior	$112
D2510	Inlay - metallic - one surface	$390
D2520	Inlay - metallic - two surfaces	$390
D2530	Inlay - metallic - three or more surfaces	$407
D2542	Onlay - metallic - two surfaces	$423
D2543	Onlay - metallic - three surfaces	$511
D2544	Onlay - metallic – 4 or more surfaces	$511
D2610	Inlay - porcelain/ceramic - one surface	$410
D2620	Inlay - porcelain/ceramic - two surfaces	$410
D2630	Inlay - porcelain/ceramic - three or more surfaces	$427
D2642	Onlay - porcelain/ceramic - two surfaces	$439
D2643	Onlay - porcelain/ceramic - three surfaces	$459
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$459
D2650	Inlay - resin-based composite - one surface	$425
D2651	Inlay - resin-based composite - two surfaces	$425
D2652	Inlay - resin-based composite - three or more surfaces	$425
D2662	Onlay - resin-based composite - two surfaces	$429
D2663	Onlay - resin-based composite - three surfaces	$429

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†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Advantage Plus covered dental services	*What you must pay
D2664	Onlay - resin-based composite - >=4 surfaces	$429
D2710	Crown - resin (indirect)	$259
D2712	Crown - 3/4 resin-based composite (exclusive of veneers)	$450
D2720	Crown - resin with high noble metal	$470
D2721	Crown - resin with predominantly base metal	$470
D2722	Crown - resin with noble metal	$470
D2740	Crown - porcelain/ceramic	$531
D2750	Crown - porcelain fused to high noble metal	$495
D2751	Crown - porcelain fused to predominantly base metal	$495
D2752	Crown - porcelain fused to noble metal	$495
D2780	Crown - 3/4 cast high noble metal	$457
D2781	Crown - 3/4 cast predominantly base metal	$457
D2782	Crown - 3/4 cast noble metal	$457
D2783	Crown - 3/4 porcelain/ceramic	$469
D2790	Crown - full cast high noble metal	$481
D2791	Crown - full cast predominantly base metal	$481
D2792	Crown - full cast noble metal	$481
D2910	Recement inlay	$41
D2920	Recement crown	$41
D2931	Prefabricated stainless steel crown - permanent tooth	$119
D2932	Prefabricated resin crown	$135
D2940	Protective restoration	$37
D2950	Core buildup, including any pins	$120
D2951	Pin retention - per tooth, in addition to restoration	$22
D2952	Post and core in addition to crown	$181
D2954	Prefabricated post and core in addition to crown	$148
D2955	Post removal (not in conj. with endo. therapy)	$101
D2980	Crown repair necessitated by restorative material failure	$93
D2981	Inlay repair necessitated by restorative material failure	$93
D2982	Onlay repair necessitated by restorative material failure	$93

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.
†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Advantage Plus covered dental services	*What you must pay
Endodontic Services		
D3110	Pulp cap - direct (excluding final restoration)	$28
D3120	Pulp cap - indirect (excluding final restoration)	$28
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$81
D3221	Pulpal debridement, prim. and perm. teeth	$87
D3310	Endodontic therapy, anterior (excluding final restoration)	$325
D3320	Endodontic therapy, premolar (excluding final restoration)	$395
D3330	Endodontic therapy, molar (excluding final restoration)	$488
D3333	Internal root repair of perforation defects	$96
D3346	Retreatment of previous root canal therapy - anterior	$356
D3347	Retreatment of previous root canal therapy - premolar	$418
D3348	Retreatment of previous root canal therapy - molar	$527
D3410	Apicoectomy - anterior	$310
D3421	Apicoectomy - premolar (first root)	$333
D3425	Apicoectomy - molar (first root)	$379
D3426	Apicoectomy (each additional root)	$148
D3430	Retrograde filling - per root	$113
D3450	Root amputation - per root	$202
D3920	Hemisection (including any root removal), not including root canal therapy	$202
D3950	Canal prep/fitting of preformed dowel or post	$125
Periodontic Services		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth per quadrant	$265
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant	$94
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth	$324
D4241	Gingival flap procedure, including root planing - one to three teeth, per quadrant	$90
D4260	Osseous surgery (including flap entry and closure) - four or more per quadrant	$485

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.
†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Advantage Plus covered dental services	*What you must pay
D4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant	$360
D4263	Bone replacement graft - retained natural tooth - first site in quad	$502
D4264	Bone replacement graft - retained natural tooth - each additional site in quad	$393
D4265	Biological materials to aid in soft and osseous tissue regeneration	$275
D4268	Surgical revision procedure, per tooth	$329
D4270	Pedicle soft tissue graft procedure	$434
D4273	Autogenous connective tissue graft procedure, first tooth	$540
D4274	Mesial/distal wedge procedure, single tooth	$308
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$576
D4277	Free soft tissue graft procedure, first tooth	$441
D4278	Free soft tissue graft procedure, each add. tooth	$68
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	$105
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	$57
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$39
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$77
D4381	Localized delivery of chemotherapeutic agents	$90
D4910	Periodontal maintenance	$66
Prosthetics - Removable		
D5110	Complete denture - maxillary	$664
D5120	Complete denture - mandibular	$664
D5130	Immediate denture - maxillary	$708
D5140	Immediate denture - mandibular	$708
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$613
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$613

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.
†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Advantage Plus covered dental services	*What you must pay
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$722
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$722
D5221	Immediate maxillary partial denture	$613
D5222	Immediate mandibular partial denture	$613
D5223	Immediate maxillary partial denture	$722
D5224	Immediate mandibular partial denture	$722
D5225	Maxillary partial denture	$722
D5226	Mandibular partial denture	$722
D5282	Removable unilateral partial denture - one piece cast metal, maxillary	$397
D5283	Removable unilateral partial denture - one piece cast metal, mandibular	$397
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$397
D5410	Adjust complete denture - maxillary	$35
D5411	Adjust complete denture - mandibular	$35
D5421	Adjust partial denture - maxillary	$35
D5422	Adjust partial denture - mandibular	$35
D5511	Repair broken complete denture base - mandibular	$84
D5512	Repair broken complete denture base - maxillary	$84
D5520	Replace missing or broken teeth - complete denture (each tooth)	$84
D5611	Repair resin partial denture base - mandibular	$84
D5612	Repair resin partial denture base - maxillary	$84
D5621	Repair cast partial framework - mandibular	$84
D5622	Repair cast partial framework - maxillary	$84
D5630	Repair or replace broken clasp	$112
D5640	Replace broken teeth - per tooth	$84
D5650	Add tooth to existing partial denture	$84
D5660	Add clasp to existing partial denture	$112
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$263
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$263

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.
†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Advantage Plus covered dental services	*What you must pay
D5710	Rebase complete maxillary denture	$253
D5711	Rebase complete mandibular denture	$253
D5720	Rebase maxillary partial denture	$253
D5721	Rebase mandibular partial denture	$253
D5730	Reline complete maxillary denture (chairside)	$152
D5731	Reline complete mandibular denture (chairside)	$152
D5740	Reline maxillary partial denture (chairside)	$152
D5741	Reline mandibular partial denture (chairside)	$152
D5750	Reline complete maxillary denture (laboratory)	$214
D5751	Reline complete mandibular denture (laboratory)	$214
D5760	Reline maxillary partial denture (laboratory)	$214
D5761	Reline mandibular partial denture (laboratory)	$214
D5810	Interim complete denture (maxillary)	$333
D5811	Interim complete denture (mandibular)	$333
D5820	Interim partial denture (maxillary)	$333
D5821	Interim partial denture (mandibular)	$333
D5850	Tissue conditioning, maxillary	$75
D5851	Tissue conditioning, mandibular	$75
Prosthetics — Fixed		
D6000-D6199	All implant services - 15% discount (includes D0360-D0363 cone beam imaging with implants)	
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$57
D6210	Pontic - cast high noble metal	$481
D6211	Pontic - cast predominantly base metal	$481
D6212	Pontic - cast noble metal	$481
D6240	Pontic - porcelain fused to high noble metal	$495
D6241	Pontic - porcelain fused to predominantly base metal	$495
D6242	Pontic - porcelain fused to noble metal	$495
D6245	Pontic - porcelain/ceramic	$531

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.
†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Advantage Plus covered dental services	*What you must pay
D6250	Pontic - resin with high noble metal	$470
D6251	Pontic - resin with predominantly base metal	$470
D6252	Pontic - resin with noble metal	$470
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$233
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	$364
D6549	Resin retainer - for resin bonded fixed prosthesis	$233
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$410
D6601	Retainer inlay - porcelain/ceramic, >=3 surfaces	$427
D6602	Retainer inlay - cast high noble metal, two surfaces	$390
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$407
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$390
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$407
D6606	Retainer inlay - cast noble metal, two surfaces	$390
D6607	Retainer inlay - cast noble metal, three or more surfaces	$407
D6608	Retainer onlay -porcelain./ceramic, two surfaces	$439
D6609	Retainer onlay - porcelain./ceramic, three or more surfaces	$459
D6610	Retainer onlay - cast high noble metal, two surfaces	$423
D6611	Retainer onlay cast high noble metal >=3 surfaces	$511
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$423
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$511
D6614	Retainer onlay - cast noble metal, two surfaces	$423
D6615	Retainer onlay cast noble metal >=3 surfaces	$511
D6720	Retainer crown - resin with high noble metal	$470
D6721	Retainer crown - resin with predominantly base metal	$470
D6722	Retainer crown - resin with noble metal	$470
D6740	Retainer crown – Porcelain/ceramic	$531
D6750	Retainer crown - porcelain fused to high noble metal	$495
D6751	Retainer crown - porcelain fused to predominantly base metal	$495
D6752	Retainer crown - porcelain fused to noble metal	$495
D6780	Retainer crown - 3/4 cast high noble metal	$457

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.
†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Advantage Plus covered dental services	*What you must pay
D6781	Retainer crown - 3/4 cast predominantly base metal	$457
D6782	Retainer crown - 3/4 cast noble metal	$457
D6783	Retainer crown - 3/4 porc./ceramic	$469
D6790	Retainer crown - full cast high noble metal	$481
D6791	Retainer crown - full cast predominantly base metal	$481
D6792	Retainer crown - full cast noble metal	$481
D6930	Recement or rebond fixed partial denture	$66
D6980	Fixed partial denture repair, by report	$157
Oral Surgery		
D7111	Extraction, coronal remnants - primary tooth	$45
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$63
D7210	Extraction of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$127
D7220	Removal of impacted tooth - soft tissue	$144
D7230	Removal of impacted tooth - partially bony	$189
D7240	Removal of impacted tooth - completely bony	$227
D7241	Removal of impacted tooth - completely bony, with unusual surg. complications	$181
D7250	Removal of residual tooth roots (cutting procedure)	$136
D7251	Coronectomy - intentional partial tooth removal	$181
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$211
D7280	Exposure of an unerupted tooth	$111
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$41
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$135
D7320	Alveoloplasty not in conjunction with extractions – per quadrant	$135
D7510	Incision and drainage of abscess - intraoral soft tissue	$91
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$256
D7979	Non-surgical sialolithotomy	$43

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.
†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Advantage Plus covered dental services	*What you must pay
Orthodontics		
D8090	Comprehensive orthodontic treatment of the adult dentition	$3,658
D8660	Pre-orthodontic treatment visit	$413
D8670	Periodic orthodontic treatment visit (as part of contract)	$118
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$413
Additional Procedures		
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$43
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia	$0
D9219	Evaluation for deep sedation or general anesthesia	$0
D9222	Deep sedation/general anesth – first 15 minute increment	$103
D9223	Deep sedation/general anesth – each subsequent 15 minute increment	$103
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$37
D9239	Intrav moderate sedation/analgesia – first 15 minute increment	$103
D9243	Intrav moderate sedation/analgesia - each subsequent 15 minute increment	$103
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$43
D9613	Infiltration of sustained release therapeutic drug – single or multiple sites	$190
D9910	Application of desensitizing medicament	$31
D9930	Treatment of complications (post-surgical)	$43
D9944	Occlusal guard – hard appliance, full arch	$298
D9945	Occlusal guard – soft appliance, full arch	$298
D9946	Occlusal guard – hard appliance, partial arch	$298
D9950	Occlusion analysis - mounted case	$81
D9951	Occlusal adjustment - limited	$62
D9952	Occlusal adjustment - complete	$255
D9986	Missed appointment	$50

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.
†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

ADA Code	Advantage Plus covered dental services	*What you must pay
D9995	Teledentistry – synchronous; real-time encounter	$20
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	$20

SECTION 3. What services are not covered by our plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and, therefore, are not covered by this plan. If a service is "excluded," it means that we don't cover the service.

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

If you get services that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception is we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3, in this booklet.)

All exclusions or limitations on services are described in the Benefits Chart or in the chart below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare		√ This exclusion doesn't apply to services or items that aren't covered by Original Medicare but are covered by our plan.
Experimental medical and surgical procedures, equipment and medications		√

*Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.
†Your provider must obtain prior authorization from our plan.
Note: You must pay a $10 copayment (D9439) each time you receive dental care in addition to any other cost-sharing listed above.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
• Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		May be covered by Original Medicare under a Medicare-approved clinical research study. (See Chapter 3, Section 5 for more information about clinical research studies.)
Private room in a hospital		√ Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	√	
Full-time nursing care in your home	√	
Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care. • Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	√	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation	√	
Fees charged by your immediate relatives or members of your household	√	
Cosmetic surgery or procedures		√ Covered in cases of an accidental injury or for improvement of the

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Routine dental care, such as cleanings, fillings, or dentures for Basic Option or Basic Part B Only Option plan members	√	
Nonroutine dental care for Basic Option or Basic Part B Only Option plan members		√ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Routine chiropractic care		√ Manual manipulation of the spine to correct a subluxation is covered.
Routine foot care		√ Some limited coverage provided according to Medicare guidelines (for example, if you have diabetes).
Home-delivered meals	√	
Orthopedic shoes		√ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
Supportive devices for the feet		√ Orthopedic or therapeutic footwear for people with diabetic foot disease.
Routine hearing exams	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Hearing aids or exams to fit hearing aids		√ This exclusion doesn't apply to cochlear implants and osseointegrated external hearing devices covered by Medicare. Also, this exclusion doesn't apply for High Option and Standard Option plan members if you are enrolled in Advantage Plus (see Section 2.2 for details). However, the Advantage Plus hearing aid benefit doesn't cover the following services or items: • Internally implanted hearing aids. • Replacement parts, batteries, repair of hearing aids, and replacement of lost or broken hearing aids (the manufacturer warranty may cover some of these). • Hearing aids prescribed or ordered before you were an Advantage Plus member.
Routine eye exams, eyeglasses, and contact lenses for Basic Option or Basic Part B Only Option plan members		√ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Radial keratotomy, LASIK surgery, and other low-vision aids	√	
Reversal of sterilization procedures and non-prescription contraceptive supplies	√	
Infertility services	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture	√	
Naturopath services (uses natural or alternative treatments)	√	
Care in a licensed intermediate care facility	√	
Comfort, convenience, or luxury equipment or features	√	
Private duty nursing	√	
Outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas and food	√	
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance)		√ Covered if medically necessary and covered under Original Medicare.
Services provided to veterans in Veterans Affairs (VA) facilities		√ When emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our plan's cost-sharing amounts.
Reconstructive surgery that offers only a minimal improvement in appearance or is performed to alter or reshape normal structures of the body in order to improve appearance		√ We cover reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defect, developmental abnormalities, accidental injury, trauma, infection,

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		tumors, or disease, if a network physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible.
Surgery that, in the judgment of a network physician specializing in reconstructive surgery, offers only a minimal improvement in appearance. • Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance	√	
Nonconventional intraocular lenses (IOLs) following cataract surgery (for example, a presbyopia-correcting IOL)		√ You may request and we may provide insertion of a presbyopia-correcting IOL or astigmatism-correcting IOL following cataract surgery in lieu of a conventional IOL. However, you must pay the difference between Plan Charges for a nonconventional IOL and associated services and Plan Charges for insertion of a conventional IOL following cataract surgery.
Massage therapy		√ Covered when ordered as part of physical therapy program in accord with Medicare guidelines.
Travel and lodging expenses		√ Provided only in connection with out-of-area transplant services that we cover.
Transportation by air, car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
licensed ambulance), even if it is the only way to travel to a network provider		
Licensed ambulance services without transport		√ Covered if the ambulance transports you or if covered by Medicare.
Physical exams and other services (1) required for obtaining or maintaining employment or participation in employee programs, (2) required for insurance or licensing, or (3) on court order or required for parole or probation		√ Covered if a network physician determines that the services are medically necessary or medically appropriate preventive care.
Services related to noncovered services or items		√ When a service or item is not covered, all services related to the noncovered service or item are excluded, (1) except for services or items we would otherwise cover to treat complications of the noncovered service or item, or (2) unless covered in accord with Medicare guidelines.
Services not approved by the federal Food and Drug Administration. Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S., but are not approved by the FDA		√ This exclusion applies to services provided anywhere, even outside the U.S. It doesn't apply to Medicare-covered clinical trials or covered emergency care you receive outside the U.S.
Industrial frames for High or Standard plans with eyewear benefits	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Lenses and sunglasses without refractive value and replacement of lost, broken, or damaged lenses or frames for High or Standard plans with eyewear benefits		√ This exclusion doesn't apply to any of the following items: • A clear balance lens if only one eye needs correction. • Tinted lenses when medically necessary to treat macular degeneration or retinitis pigmentosa.
Eyeglass or contact lens adornment, such as engraving, faceting, or jeweling for High or Standard plans with eyewear benefits	√	
Eyewear items that do not require a prescription by law (other than eyeglass frames), such as eyeglass holders, eyeglass cases, and repair kits for High or Standard plans with eyewear benefits	√	
Exclusions described in the amendment "What You Need to Know — Your Important State-mandated Health Care Benefits and Rights and Other Legal Notices"	√	

Advantage Plus dental exclusions

- Services which are not necessary for the patient's dental health as determined by the Plan.
- Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the Dental Administrator.
- Noble and precious metals. An additional fee will be charged if these materials are used.
- Oral surgery requiring the setting of fractures or dislocations.
- Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where, in the opinion of the Dental Administrator, such services should not be performed in a dental office.

- Dental treatment required for conditions resulting from major disaster, epidemic, war, acts of war, whether declared or undeclared, or while on active duty as a member of the armed forces of any nation.
- Replacement due to loss or theft of prosthetic appliance.
- Procedures not listed as covered benefits in Section 2.2 of this chapter.
- Services obtained outside of the dental office in which enrolled and that are not preauthorized by such office or the Health Plan or Dental Administrator (except for covered out-of-area dental emergencies).
- Services related to the treatment of TMD (Temporomandibular Disorder).
- Services related to procedures that are of such a degree of complexity as to not be normally performed by a participating dental provider, unless referred by your general dentist to a dental specialist who will provide covered dental services at the dental fee established by the Plan for each procedure rendered.
- Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth as determined by the Dental Administrator.
- The Invisalign system and similar appliances are not a covered benefit. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient's responsibility.
- Services which are provided without cost to member by any federal, state, municipal, county, or other political subdivision (with the exception of Medicaid).
- Services that cannot be performed because of the general health of the patient.
- Implantation and related restorative procedures.
- Procedures relating to the change and maintenance of vertical dimension or major restoration of occlusion, or to alter the occlusion (bite) through full mouth adjustment/grinding of the teeth. This does not exclude minor occlusal adjustments on individual teeth to remove high spots or smooth out rough or sharp areas.
- Lab fees for excisions and biopsies, except as may be otherwise covered in your medical plan that is described in the Agreement or your Evidence of Coverage.
- Experimental procedures, implantations, or pharmacological regimens.
- Initial placement or replacement of fixed bridgework solely for the purpose of achieving periodontal stability.
- Charges for second opinions, unless pre-authorized.
- Procedures requiring fixed prosthodontic restoration, which are necessary for complete oral rehabilitation or reconstruction.
- Occlusal guards, except for the purpose of controlling habitual grinding.
- Dental services for children under age 19.
- Any bill, or demand for payment, for a service that the regulatory board determines was provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.

Advantage Plus dental limitations

- Two (2) evaluations are covered per Plan year per patient including a maximum of one (1) comprehensive evaluation which is limited to once in 12 months.
- One (1) problem focused exam is covered per Plan year per patient.
- Two (2) teeth cleanings (prophylaxis) are covered per Plan year per patient (one additional cleaning is covered during pregnancy and for diabetic patients).
- One (1) topical fluoride or fluoride varnish is covered per Plan year per patient.
- Two (2) sets of bitewing x-rays are covered per Plan year per patient.
- One (1) set of full mouth x-rays or panoramic film is covered every three (3) years per patient.
- Replacement of a filling is covered if it is more than two (2) years from the date of original placement.
- Replacement of a bridge, crown or denture is covered if it is more than seven (7) years from the date of original placement.
- Crown and bridge fees apply to treatment involving five or fewer units when presented in a single treatment plan. Additional crown or bridge units, beginning with the sixth unit, are available at the provider's Usual, Customary, and Reasonable (UCR) fee, minus 25%.
- Relining and rebasing of dentures is covered once every 24 months per patient.
- Retreatment of root canal is covered if it is more than two (2) years from the original treatment.
- Root planing or scaling is covered once every 24 months per quadrant per patient.
- Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation and in lieu of a covered D1110, limited to once per two years.
- Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.
- Full mouth debridement is covered once per lifetime per patient.
- Procedure Code D4381 is limited to one (1) benefit per tooth for three teeth per quadrant or a total of 12 teeth for all four quadrants per twelve (12) months per patient. Must have pocket depths of five (5) millimeters or greater.
- Periodontal surgery of any type, including any associated material, is covered once every 36 months per quadrant or surgical site per patient.
- Periodontal maintenance after active therapy is covered twice per Plan year, within 24 months after definitive periodontal therapy, per patient.
- Coronectomy - intentional partial tooth removal, once per lifetime.
- Teledentistry, synchronous (D9995) or asynchronous (D9996), limited to two per calendar year (when available).

CHAPTER 5. Asking us to pay our share of a bill you have received for covered medical services

SECTION 1. Situations in which you should ask us to pay our share of the cost of your covered services

Section 1.1 If you pay our share of the cost of your covered services, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of our plan. In either case, you can ask us to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask us to pay you back or to pay a bill you have received:

When you've received emergency or urgently needed medical care from a provider who is not in our network

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill our plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

When a network provider sends you a bill you think you should not pay

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

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service, and even if there is a dispute and we don't pay certain provider charges. For more information about "balance billing," go to Chapter 4, Section 1.3.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

If you are retroactively enrolled in our plan

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

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

Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request. Phone numbers for Member Services are printed on the back cover of this booklet.

Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this booklet, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," has information about how to make an appeal.

SECTION 2. How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (**kp.org**) or call Member Services and ask for the form. Phone numbers for Member Services are printed on the back cover of this booklet.

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

Mid-Atlantic Claims Administration
Kaiser Permanente

P.O. Box 371860
Denver, CO 80237-9998

You must submit your claim to us within 365 days after service date.

Contact Member Services if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3. We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service and how much we owe

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

- If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered.)
- If we decide that the medical care is not covered, or you did not follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details about how to make this appeal, go to Chapter 7 of this booklet, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." The appeals process is a detailed legal process with complicated procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives you definitions of terms such as "appeal." Then, after you have read Section 4, you can go to the section in Chapter 7 that tells you what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.3 in Chapter 7.

CHAPTER 6. Your rights and responsibilities

SECTION 1. We must honor your rights as a member of our plan

Section 1.1 We must provide information in a way that works for you (in languages other than English, Braille, or large print)

To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English-speaking members. We can also give you information in Braille or large print at no cost if you need it. We are required to give you information about our plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet) or contact our Civil Rights Coordinator.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services (phone numbers are printed on the back cover of this booklet). You may also file a complaint with Medicare by calling **1-800-MEDICARE (1-800-633-4227)** or directly with the Office for Civil Rights. Contact information is included in this **Evidence of Coverage** or with this mailing, or you may contact Member Services for additional information.

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

As a member of our plan, you have the right to choose a primary care provider (PCP) in our network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral, as well as other providers described in Chapter 3, Section 2.2.

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

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9, of this booklet tells you what you can do. (If we have denied coverage for your medical care and you don't agree with our decision, Chapter 7, Section 4, tells you what you can do.)

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

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations.

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are printed on the back cover of this booklet).

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

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in Braille or large print.)

If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about our plan's financial condition. It also includes information about the number of appeals made by

members and our plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.

- **Information about our network providers.**
  - For example, you have the right to get information from us about the qualifications of the providers in our network and how we pay the providers in our network.
  - For a list of the providers in our network, see the **Provider Directory**.
  - For more detailed information about our providers, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at **kp.org/directory**.
- **Information about your coverage and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an out-of-network provider.
  - If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells you about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask us to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

Section 1.5 We must treat you with dignity and respect and support your right to make decisions about your care

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

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 7 of this booklet tells you how to ask us for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

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

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

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form**. If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms (phone numbers are printed on the back cover of this booklet).
- **Fill it out and sign it**. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with:

Maryland Residents: Maryland Insurance Administration Consumer Complaint Investigation 200 St. Paul Place, Suite 2700 Baltimore, MD 21202	**Virginia Residents:** State Corporation Commission Virginia Bureau of Insurance P.O. Box 1157 Richmond, VA 23218

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells you what you can do. It gives you the details about how to deal with all types of problems and complaints.

What you need to do to follow up on a problem or concern depends upon the situation. You might need to ask us to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

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

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can call Member Services (phone numbers are printed on the back cover of this booklet).
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or you can call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can call Member Services (phone numbers are printed on the back cover of this booklet).
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact Medicare:
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at **https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf**.)
  - Or you can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Section 1.9 Information about new technology assessments

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

Section 1.10 You can make suggestions about rights and responsibilities

As a member of our plan, you have the right to make recommendations about the rights and responsibilities included in this chapter. Please call Member Services with any suggestions (phone numbers are printed on the back cover of this booklet).

SECTION 2. You have some responsibilities as a member of our plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of our plan are listed below. If you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this **Evidence of Coverage** booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
- **If you have any other health insurance coverage in addition to our plan, you are required to tell us**. Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health benefits you get from us with any other health benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 8.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
  - Notifying out-of-network providers when seeking care (unless it is an emergency) that although you are enrolled in our plan, the provider should bill Original Medicare. You should present your membership card and your Medicare card.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health care providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure you understand your health problems and participate in developing mutually agreed upon treatment goals with your providers whenever possible.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - In order to be eligible for our plan, you must have Medicare Part B (or both Part A and Part B). Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of our plan.
  - For most of your medical services covered by our plan, you must pay your share of the cost when you get the service. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells you what you must pay for your medical services.

- If you get any medical services that are not covered by our plan or by other insurance you may have, you must pay the full cost.
- If you disagree with our decision to deny coverage for a service, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.

- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).
  - If you move outside of our plan service area, you cannot remain a member of our plan. (Chapter 1 tells you about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a special enrollment period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - If you move within our service area, we still need to know so we can keep your membership record up-to-date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
  - For more information about how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)

Background

Coverage decisions and appeals

Making complaints

Background

SECTION 1. Introduction

Section 1.1 What to do if you have a problem or concern

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

- For some types of problems, you need to use the process for coverage decisions and appeals.
- For other types of problems, you need to use the process for making complaints.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by you and us.

Which one do you use?

That depends upon the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination" and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible.

However, it can be helpful, and sometimes quite important, for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2. You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations, you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3, of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
- You can visit the Medicare website (**https://www.medicare.gov**).

SECTION 3. To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help you with your specific problem or concern, *START HERE:*

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care is covered or not, the way in which it is covered, and problems related to payment for medical care.)

- **Yes, my problem is about benefits or coverage:**

  Go to the next section in this chapter, Section 4: "A guide to the basics of coverage decisions and appeals."

- **No, my problem is not about benefits or coverage:**

  Skip ahead to Section 9 at the end of this chapter: "How to make a complaint about quality of care, waiting times, customer service, or other concerns."

Coverage decisions and appeals

SECTION 4. A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals—*The big picture*

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for medical services, including problems related to payment. This is the process you use for issues such as whether something is covered or not, and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision, if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a service is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call Member Services** (phone numbers are printed on the back cover of this booklet).
- To get free help from an independent organization that is not connected with our plan, **contact your State Health Insurance Assistance Program** (see Section 2 in this chapter).
- **Your doctor can make a request for you.**
  - For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under state law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at **https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**.) The form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are three different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

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

If you're not sure which section you should be using, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 5. Your medical care: How to ask for a coverage decision or make an appeal

? Have you read Section 4 in this chapter ("A guide to the basics of coverage decisions and appeals")? If not, you may want to read it before you start this section.

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

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: "Medical Benefits Chart (what is covered and what you pay)." To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time. The term "medical care" includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

If you have a complaint about a bill when you receive care from an out-of-network provider, the appeals process described will not apply, unless you were directed to go to an out-of-network

provider by the plan or one of the network providers for care covered by our plan (for example, an authorized referral).

You should refer to the notice of the service (called the "Medicare Summary Notice") you receive from Original Medicare. The Medicare Summary Notice provides information on how to appeal a decision made by Original Medicare.

This section tells you what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. We will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by our plan.
3. You have received medical care or services that you believe should be covered by our plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by our plan, and you want to ask us to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:

- **Chapter 7, Section 6:** "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon."
- **Chapter 7, Section 7:** "How to ask us to keep covering certain medical services if you think your coverage is ending too soon." This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.

For all other situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section in this chapter, **Section 5.2**.
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 5.3** in this chapter.

Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to **Section 5.5** in this chapter.

Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask us to authorize or provide the medical care coverage you want)

Legal Terms
When a coverage decision involves your medical care, it is called an "**organization determination**."

Step 1: You ask us to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a "fast coverage decision."

Legal Terms
A "fast coverage decision" is called an "**expedited determination**."

How to request coverage for the medical care you want

- Start by calling, writing, or faxing us to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details about how to contact us, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care."

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer **within 14 calendar days** after we receive your request for a medical item or service. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** after we receive your request.

- However, for a request for a medical item or service, we can take up to 14 more calendar days if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint **within 24 hours**. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 9 in this chapter.)

If your health requires it, ask us to give you a "fast coverage decision"

- A fast coverage decision means we will answer **within 72 hours** if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.
  - However, for a request for a medical item or service, we can take up to 14 more calendar days if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 in this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision only if you are asking for coverage for medical care you have not yet received. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)
  - You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.**
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 in this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a "fast coverage decision"

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint **within 24 hours**. (For more information about the process for making complaints, including fast complaints, see Section 9 in this chapter.)
- If we do not give you our answer **within 72 hours** (or if there is an extended time period, by the end of that period), or **24 hours** if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells you how to make an appeal.

- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the medical care coverage we have agreed to provide **within 72 hours** after we received your request. If we extended the time needed to make our coverage decision on your request for a medical item or service, we will authorize or provide the coverage by the end of that extended period.
- If our answer is ***no*** to part or all of what you requested, we will send you a detailed written explanation as to why we said no.

*Deadlines for a "**standard** coverage decision"*

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days** of receiving your request. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
  - For a request for a medical item or service, we can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint **within 24 hours**. (For more information about the process for making complaints, including fast complaints, see Section 9 in this chapter.)
  - If we do not give you our answer **within 14 calendar days** (or if there is an extended time period, by the end of that period), or **72 hours** if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells you how to make an appeal.
- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide **within 14 calendar days**, or **72 hours** if your request is for a Part B prescription drug, after we received your request.
  If we extended the time needed to make our coverage decision on your request for a medical item or service, we will authorize or provide the coverage by the end of that extended period.
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said no.

Step 3: If we say *no* to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say ***no***, you have the right to ask us to reconsider, and perhaps change this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.

- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

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

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a "fast appeal."

What to do:

- **To start an appeal, you, your doctor, or your representative must contact us.** For details about how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care."
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.**

If you have someone appealing our decision for you other than your doctor, your appeal must include an "Appointment of Representative" form authorizing this person to represent you. To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at **https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**. While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1, "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care."
- **You must make your appeal request within 60 calendar days from the date on the written notice** we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.

- If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

Legal Terms
A "fast appeal" is also called an "**expedited reconsideration**."

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said ***no*** to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a "fast appeal"

- When we are using the fast deadlines, we must give you our answer **within 72 hours** after we receive your appeal**.** We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If we do not give you an answer **within 72 hours** (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide **within 72 hours** after we receive your appeal.
- If our answer is ***no*** to part or all of what you requested, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug, we will give you our answer **within 7 calendar days** after we receive

your appeal if your appeal is about coverage for a Part B prescription drug you have not yet received. We will give you our decision sooner if your health condition requires us to.

- However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint **within 24 hours**. (For more information about the process for making complaints, including fast complaints, see Section 9 in this chapter.)
- If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent, outside organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.

- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide **within 30 calendar days**, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug after we receive your appeal.
- If our answer is ***no*** to part or all of what you requested, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says *no* to part or all of your appeal, your case will automatically be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said ***no*** to your appeal, we are required to send your appeal to the Independent Review Organization. When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How a Level 2 Appeal is done

If we say ***no*** to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the "**Independent Review Entity.**" It is sometimes called the "**IRE**."

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This

organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- We will send the information about your appeal to this organization. This information is called your "case file." You have the right to ask us for a copy of your case file. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

*If you had a "fast appeal" at Level 1, you will also have a "**fast appeal**" at Level 2*

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours of when it receives your appeal.**
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

*If you had a "standard appeal" at Level 1, you will also have a "**standard appeal**" at Level 2*

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. If your request is for a medical item or service, the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service, the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- If the review organization says ***yes*** to part or all of a request for a medical item or service, we must authorize the medical care coverage **within 72 hours** or provide the service **within 14 calendar days** after we receive the decision from the review organization for standard requests or **within 72 hours** from the date we receive the decision from the review organization for expedited requests.
- If the review organization says ***yes*** to part or all of a request for a Medicare Part B prescription drug, we must authorize the Part B prescription drug under dispute **within 72 hours** after we receive the decision from the review organization for standard requests or **within 24 hours** from the date we receive the decision from the review organization for expedited requests.

- If this organization says ***no*** to part or all of your appeal, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
  - If the Independent Review Organization "upholds the decision," you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge or attorney adjudicator. Section 8 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 5 of this booklet: "Asking us to pay our share of a bill you have received for covered medical services." Chapter 5 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells you how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 in this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service; see Chapter 4, "Medical Benefits Chart (what is covered and what you pay)." We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: "Using our plan's coverage for your medical services").

We will say *yes* or *no* to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care **within 60 calendar days** after we receive your request. Or if you haven't paid for the services, we will send the payment directly to the provider. (When we send the payment, it's the same as saying ***yes*** to your request for a coverage decision.)

- If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying ***no*** to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

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

To make this appeal, follow the process for appeals that we describe in Section 5.3. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer **within 60 calendar days** after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider **within 30 calendar days**. If the answer to your appeal is ***yes*** at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider **within 60 calendar days**.

SECTION 6. How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: "Medical Benefits Chart (what is covered and what you pay)."

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**."
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

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

During your covered hospital stay, you will be given a written notice called **An Important Message from Medicare about Your Rights**. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Services

(phone numbers are printed on the back cover of this booklet). You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

- Read this notice carefully and ask questions if you don't understand it. It tells you about your rights as a hospital patient, including:
  - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
  - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
  - Where to report any concerns you have about quality of your hospital care.
  - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms
The written notice from Medicare tells you how you can "**request an immediate review**." Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 6.2 below tells you how you can request an immediate review.)

- **You must sign the written notice** to show that you received it and understand your rights.
  - You or someone who is acting on your behalf must sign the notice. (Section 4 in this chapter tells you how you can give written permission to someone else to act as your representative.)
  - Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice does **not** mean you are agreeing on a discharge date.
- **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
  - If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
  - To look at a copy of this notice in advance, you can call Member Services (phone numbers are printed on the back cover of this booklet) or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. You can also see it online at **https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html**.

Section 6.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 in this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

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

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (**An Important Message from Medicare About Your Rights**) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization **before** you leave the hospital and **no later than your planned discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
  - **If you meet this deadline,** you are allowed to stay in the hospital after your discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - **If you do not meet this deadline,** and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

Ask for a "fast review":

- You must ask the Quality Improvement Organization for a "fast review" of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

Legal Terms
A "fast review" is also called an "**immediate review**" or an "**expedited review**."

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

What happens during this review?

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

Legal Terms
This written explanation is called the "**Detailed Notice of Discharge**." You can get a sample of this notice by calling Member Services (phone numbers are printed on the back cover of this booklet) or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. (TTY users should call **1-877-486-2048**.) Or you can see a sample notice online at **https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html**.

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

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

- If the review organization says ***yes*** to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet.)

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

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

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

- If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 6.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeals process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

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

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

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

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

*If the review organization says **yes**:*

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

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

- It means they agree with the decision they made on your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an administrative law judge or attorney adjudicator.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an administrative law judge or attorney adjudicator.
- Section 8 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 6.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 6.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, the first two levels of appeal are different.

Step-by-step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms
A "fast review" (or "fast appeal") is also called an "**expedited appeal**."

Step 1: Contact us and ask for a "fast review."

- For details about how to contact us, **go to Chapter 2**, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care."
- **Be sure to ask for a** "**fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast review" of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say *yes* to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say *no* to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
- **If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you received after the planned discharge date.**

*Step 4: If we say **no** to your fast appeal, your case will automatically be sent on to the next level of the appeals process.*

- To make sure we were following all the rules when we said ***no*** to your fast appeal**,** we are required to send your appeal to the Independent Review Organization. When we do this, it means that you are **automatically** going on to Level 2 of the appeals process.

Step-by-step: Level 2 Alternate Appeal Process

If we say ***no*** to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said ***no*** to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the "**Independent Review Entity**." It is sometimes called the "**IRE**."

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization **within 24 hours** of when we tell you that we are saying ***no*** to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeals process. Section 9 in this chapter tells you how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- If this **organization says *yes*** to your appeal, then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue our plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by an administrative law judge or attorney adjudicator.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say ***no*** to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 8 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

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

Section 7.1 *This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is **only** about the following types of care:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 10, "Definitions of important words.")
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 10, "Definitions of important words.")

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information about your covered services, including your share of the cost and

any limitations to coverage that may apply, see Chapter 4 of this booklet: "Medical Benefits Chart (what is covered and what you pay)."

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, **we will stop paying our share of the cost for your care.**

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

Section 7.2 We will tell you in advance when your coverage will be ending

- **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
  - The written notice tells you the date when we will stop covering the care for you.
  - The written notice also tells you what you can do if you want to ask us to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms

In telling you what you can do, the written notice is telling how you can request a "**fast-track appeal**." Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells you how you can request a fast-track appeal.)

The written notice is called the "**Notice of Medicare Non-Coverage**." To get a sample copy, call Member Services (phone numbers are printed on the back cover of this booklet) or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. (TTY users should call **1-877-486-2048**.) Or see a copy online at **https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html**.

- You must sign the written notice to show that you received it.
  - You or someone who is acting on your behalf must sign the notice. (Section 4 tells you how you can give written permission to someone else to act as your representative.)
  - Signing the notice shows **only** that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with us that it's time to stop getting the care.

Section 7.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

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

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 in this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 in this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: Contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal no later than noon of the day after you receive the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5 in this chapter.

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers inform us of your appeal, you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms
This notice of explanation is called the "**Detailed Explanation of Non-Coverage**."

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

*What happens if the reviewers say **yes** to your appeal?*

- If the reviewers say ***yes*** to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

*What happens if the reviewers say **no** to your appeal?*

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

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

- This first appeal you make is "Level 1" of the appeals process. If reviewers say ***no*** to your Level 1 Appeal, and you choose to continue getting care after your coverage for the care has ended, then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

Here are the steps for Level 2 of the appeals process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

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

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

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

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

*What happens if the review organization says **yes** to your appeal?*

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

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

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an administrative law judge or attorney adjudicator.

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an administrative law judge or attorney adjudicator.
- Section 8 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 7.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

Step-by-step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms
A "fast review" (or "fast appeal") is also called an "**expedited appeal**."

Step 1: Contact us and ask for a "fast review."

- For details about how to contact us, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care."
- **Be sure to ask for a** "**fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast review" of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending our plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say *yes* to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say *no* to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end, **then you will have to pay the full cost of this care yourself**.

*Step 4: If we say **no** to your fast appeal, your case will automatically go on to the next level of the appeals process.*

- To make sure we were following all the rules when we said ***no*** to your fast appeal, **we are required to send your appeal to the Independent Review Organization**. When we do this, it means that you are automatically going on to Level 2 of the appeals process.

Step-by-step: Level 2 Alternate Appeal Process

If we say ***no*** to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said ***no*** to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the "**Independent Review Entity**." It is sometimes called the "**IRE.**"

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization **within 24 hours** of when we tell you that we are saying ***no*** to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeals process. Section 9 in this chapter tells you how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- The **Independent Review Organization** is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes*** to your appeal, then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say ***no*** to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an administrative law judge or attorney adjudicator.
- Section 8 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

SECTION 8. Taking your appeal to Level 3 and beyond

Section 8.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge (called an administrative law judge) or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the administrative law judge or attorney adjudicator says *yes* to your appeal, the appeals process may or may *not* be over.** We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
  - If we decide **not** to appeal the decision, we must authorize or provide you with the service **within 60 calendar days** after receiving the administrative law judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the administrative law judge or attorney adjudicator says *no* to your appeal, the appeals process may or may *not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge or attorney adjudicator says ***no*** to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal: The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is *yes*, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may *not* be over.** We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
  - If we decide **not** to appeal the decision, we must authorize or provide you with the service **within 60 calendar days** after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is *no* or if the Council denies the review request, the appeals process may or may *not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says ***no*** to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal: A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

Making complaints

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

? If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 in this chapter.

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

This section explains how to use the process for making complaints. The complaint process is ***only*** used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive.

1-888-777-5536 (TTY 711), 7 days a week, 8 a.m. to 8 p.m.

If you have a complaint regarding a service provided by a hospital or skilled nursing facility that is not part of our network, follow the complaint process established by Original Medicare. However, if you have a complaint involving a network hospital or skilled nursing facility (or you were directed to go to an out-of-network hospital or skilled nursing facility by our plan or one of the network providers), you will follow the instructions contained in this section. This is true even if you received a Medicare Summary Notice indicating that a claim was processed but not covered by Original Medicare. Furthermore, if you have a complaint regarding an emergency or urgently needed service, or the cost-sharing for hospital or skilled nursing facility services, you will follow the instructions contained in this section. If you have complaints about optional supplemental benefits, you may also file an appeal.

Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint":

- **Quality of your medical care**
  - Are you unhappy with the quality of care you have received (including care in the hospital)?
- **Respecting your privacy**
  - Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
- **Disrespect, poor customer service, or other negative behaviors**
  - Has someone been rude or disrespectful to you?
  - Are you unhappy with how our Member Services has treated you?
  - Do you feel you are being encouraged to leave our plan?
- **Waiting times**
  - Are you having trouble getting an appointment, or waiting too long to get it?
  - Have you been kept waiting too long by doctors or other health professionals? Or by Member Services or other staff at our plan?
  - Examples include waiting too long on the phone, in the waiting room, or in the exam room.
- **Cleanliness**
  - Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
- **Information you get from our plan**
  - Do you believe we have not given you a notice that we are required to give?
  - Do you think written information we have given you is hard to understand?

Timeliness (these types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)

The process of asking for a coverage decision and making appeals is explained in Sections 4–8 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint.
- If you believe our plan is not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and our plan is told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 9.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms
• What this section calls a "complaint" is also called a "grievance." • Another term for "making a complaint" is "filing a grievance." • Another way to say "using the process for complaints" is "using the process for filing a grievance."

Section 9.3 Step-by-step: Making a complaint

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

- **Usually calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. Call toll-free **1-888-777-5536** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to you in writing. We will also respond in writing when you make a complaint by phone if you request a written response or your complaint is related to quality of care.
- **If you have a complaint, we will try to resolve your complaint over the phone.** If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. Your grievance must explain your concern, such as why you are dissatisfied with the services you received. Please see Chapter 2 for whom you should contact if you have a complaint.
  - You must submit your grievance to us (orally or in writing) within 60 calendar days of the event or incident. We must address your grievance as quickly as your health requires, but no later than 30 calendar days after receiving your complaint. We may extend the time frame to make our decision by up to 14 calendar days if you ask for an extension, or if we justify a need for additional information and the delay is in your best interest.

- You can file a fast grievance about our decision not to expedite a coverage decision or appeal, or if we extend the time we need to make a decision about a coverage decision or appeal. We must respond to your fast grievance **within 24 hours**.

- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal,"** we will automatically give you a "fast complaint." If you have a "fast complaint," it means we will give you an answer **within 24 hours**.

Legal Terms
What this section calls a "**fast complaint**" is also called an "**expedited grievance**."

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about quality of care, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.

- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to **https://www.medicare.gov/MedicareComplaintForm/home.aspx**. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call **1-800-MEDICARE (1-800-633-4227)**. TTY/TDD users can call **1-877-486-2048**.

CHAPTER 8. Ending your membership in our plan

SECTION 1. Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

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

- **You might leave our plan because you have decided that you want to leave.**
  - You can disenroll from our plan at any time. Section 2 tells you more about when you can end your membership in our plan.
  - The process for voluntarily ending your membership varies depending upon what type of new coverage you are choosing. Section 3 tells you how to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

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

Section 2.1 You can end your membership at any time

You can disenroll from this plan at any time. You may switch to Original Medicare, or if you have a special enrollment period, you may enroll in a Medicare Advantage or another Medicare prescription drug plan. Your membership will usually end on the last day of the month in which we receive your request to change your plan.

Section 2.2 Where can you get more information about when you can end your membership?

If you have any questions or would like more information about when you can end your membership:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the **Medicare & You** 2020 handbook.
  - Everyone with Medicare receives a copy of **Medicare & You** each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (**https://www.medicare.gov**). Or you can order a printed copy by calling Medicare at the number below.

- You can contact **Medicare** at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

SECTION 3. How do you end your membership in our plan?

Section 3.1 To end your membership, you must ask us in writing

You may end your membership in our plan at any time during the year and change to Original Medicare. To end your membership, you must make a request in writing to us. Your membership will end on the last day of the month in which we receive your request. Contact us if you need more information on how to do this. The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan.	• Enroll in the Medicare health plan between October 15 and December 7. • You will automatically be disenrolled from our plan when your new plan's coverage begins.
• Original Medicare **with** a separate Medicare prescription drug plan.	• Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). Then contact the Medicare prescription drug plan that you want to enroll in and ask to be enrolled. • You can also contact Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call **1-877-486-2048**. • You will be disenrolled from our plan when your coverage in Original Medicare begins. If you join a Medicare prescription drug plan, that coverage should begin at this time as well.
• Original Medicare **without** a separate Medicare prescription drug plan.	• Send us a written request to disenroll. Contact Member Services if you need more information about how to do this (phone numbers are printed on the back cover of this booklet). • You can also contact Medicare at **1-800-MEDICARE (1-800-633-4227),** 24 hours a day, 7 days a week,

If you would like to switch from our plan to:	This is what you should do:
	and ask to be disenrolled. TTY users should call **1-877-486-2048**. • You will be disenrolled from our plan when your coverage in Original Medicare begins.

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

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information about when your new coverage begins.) During this time, you must continue to get your medical care through our plan.

- If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).
- If you use out-of-network providers to obtain medical services, the services are covered under Original Medicare. You will be responsible for Original Medicare's cost-sharing for such services, with the exception of emergency and urgently needed services.

SECTION 5. We must end your membership in our plan in certain situations

Section 5.1 When must we end your membership in our plan?

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

- If you no longer have Medicare Part B. Members must stay continuously enrolled in Medicare Part B.
- If you move out of our service area or you are away from our service area for more than 90 days.
  - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. Phone numbers for Member Services are printed on the back cover of this booklet.
- If you are not a United States citizen or lawfully present in the United States.

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get medical care. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

If you have questions or would like more information about when we can end your membership:

- You can call Member Services for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

We are not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 9, for information about how to make a complaint.

CHAPTER 9. Legal notices

SECTION 1. Notice about governing law

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

SECTION 2. Notice about nondiscrimination

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

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at **1-800-368-1019** (TTY **1-800-537-7697**) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call Member Services (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3. Notice about Medicare Secondary Payer subrogation rights

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

SECTION 4. Administration of this Evidence of Coverage

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

SECTION 5. Applications and statements

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

SECTION 6. Assignment

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

SECTION 7. Attorney and advocate fees and expenses

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

SECTION 8. Coordination of benefits

As described in Chapter 1 (Section 8) "How other insurance works with our plan," if you have other insurance, you are required to use your other coverage in combination with your coverage as a Medicare Plus member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. You will get your covered care as usual from network providers, and the other coverage you have will simply help pay for the care you receive.

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

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

SECTION 9. Employer responsibility

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

SECTION 10. Evidence of Coverage binding on members

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

SECTION 11. Government agency responsibility

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

SECTION 12. Member nonliability

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

SECTION 13. No waiver

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

SECTION 14. Notices

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

SECTION 15. Overpayment recovery

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

SECTION 16. Third party liability

As stated in Chapter 1, Section 8, third parties who cause you injury or illness (and/or their insurance companies) usually must pay first before Medicare or our plan. Therefore, we are

entitled to pursue these primary payments. If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered services, you must ensure we receive reimbursement for those services. **Note:** This Section 16 does not affect your obligation to pay cost-sharing for these services.

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

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain against a third party that results in any settlement proceeds or judgment, from other types of coverage that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, worker's compensation, personal injury, medical payments and all other first party types. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether you are made whole and regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred. We are not required to pay attorney fees or costs to any attorney hired by you to pursue your damages claim.

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

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Patient Financial Services Department
2101 East Jefferson Street, Rockville, Maryland 20852

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

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

SECTION 17. U.S. Department of Veterans Affairs

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

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

As stated in Chapter 1, Section 8, workers' compensation usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue primary payments under workers' compensation or employer's liability law. You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered services from the following sources:

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

SECTION 19. Important information from the Commonwealth of Virginia regarding your insurance

We are subject to regulation in this Commonwealth by the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and by the Virginia Department of Health pursuant to Title 32.1.

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact Kaiser Permanente at the following address and telephone number:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
P.O. Box 6831
2101 East Jefferson Street
Rockville MD 20849-6831
301-468-6000 or 1-800-777-7902

We recommend that you familiarize yourself with our customer satisfaction and appeals processes as described in Chapter 7: "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," and make use of it before taking any other action.

If you have been unable to contact or obtain satisfaction from the company or your agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

State Corporation Commission
Bureau of Insurance
P.O. Box 115
Richmond VA 23218
804-371-9741 or 1-800-552-7945

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, Kaiser Permanente, or the Bureau of Insurance, have your policy number available

CHAPTER 10. Definitions of important words

Advantage Plus – An optional supplemental benefits package you can choose to purchase during the Annual Enrollment Period and at other limited times. This supplemental benefits package includes hearing aid, additional dental, and additional eyewear benefits for an additional monthly premium that is added to your Kaiser Permanente Medicare Plus plan premium (see Chapter 4, Section 2.2, for more information).

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

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

Annual Enrollment Period – A set time each fall when members can change their health or drug plans. The Annual Enrollment Period is from October 15 until December 7. (As a member of a Medicare Cost Plan, you can switch to Original Medicare at any time. But you can only join a new Medicare health or drug plan during certain times of the year, such as the Annual Enrollment Period.)

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for an item or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

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

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

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

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

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," in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

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

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, or hospital outpatient visit. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services are received. (This is in addition to our plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed "copayment" amount that a plan requires when a specific service is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service that a plan requires when a specific service is received. Note: In some cases, you may not pay all applicable cost-sharing at the time you receive the services, and we will send you a bill later for the cost-sharing. For example, if you receive nonpreventive care during a scheduled preventive care visit, we may bill you later for the cost-sharing applicable to the nonpreventive care. For items ordered in advance, you pay the copayment 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 copayment when the item is ordered.

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

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

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

Deductible – The amount you must pay for health care before our plan begins to pay.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

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

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – 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.

Emergency Medical Condition – Either: (1) a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs, or (2) active labor when there isn't enough time for safe transfer to a plan hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety.

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

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

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

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (for example, bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

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

Hospice – A member who has six months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

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

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the seven-month period that begins three months before the month you turn 65, includes the month you turn 65, and ends three months after the month you turn 65.

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

Kaiser Foundation Health Plan (Health Plan) – Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., is a nonprofit corporation and a Medicare Cost Plan. This **Evidence of Coverage** sometimes refers to Health Plan as "we" or "us."

Kaiser Permanente – Kaiser Foundation Hospitals, Health Plan, and the Medical Group.

Kaiser Permanente Region – A Kaiser Foundation Health Plan organization that conducts a direct-service health care program. When you are outside our service area, you can get medically necessary health care and ongoing care for chronic conditions from designated providers in another Kaiser Permanente region's service area. For more information, please refer to Chapter 3, Section 2.2.

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

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for your plan premiums and Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.2, for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6, for information about how to contact Medicaid in your state.

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

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

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

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan, a PACE plan, or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, a PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

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).

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

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

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

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

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

Network Provider – "Provider" is the general term we use for doctors, other health care professionals (including, but not limited to, physician assistants, nurse practitioners, and nurses), hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases, to coordinate as well as provide covered services to members of our plan. We pay network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium. You must voluntarily elect Optional Supplemental Benefits in order to get them (see Chapter 4, Section 2.2, for more information).

Organization Determination – The Cost plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

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

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for "Cost-Sharing" above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's "out-of-pocket" cost requirement.

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) for as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – See **"Medicare Advantage (MA) Plan."**

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Plan – Kaiser Permanente Medicare Plus.

Plan Charges – Plan 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 cost-sharing from its payment, the amount Kaiser Permanente would have paid if it did not subtract cost-sharing.

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

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

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

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1, for information about primary care providers.

Prior Authorization – Approval in advance to get services. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4 and described in Chapter 3, Section 2.3.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4, for information about how to contact the QIO for your state.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (nonemergency) services. Our plan may disenroll you if you permanently move out of our plan's service area.

Services – Health care services or items.

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

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

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

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

Urgently Needed Services – Urgently needed services are provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

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

Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no-cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Member Services at **1-888-777-5536** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to 2101 East Jefferson Street, Rockville, MD 20852 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 1-800-537-7697 (TDD)**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Multi-language Interpreter Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-888-777-5536** (TTY: **711**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-777-5536** (TTY: **711**).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-888-777-5536**
（TTY：**711**）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-888-777-5536** (TTY: **711**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-777-5536** (TTY: **711**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-888-777-5536** (TTY: **711**)번으로 전화해 주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-777-5536** (телетайп: **711**).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-888-777-5536**（TTY:**711**）まで、お電話にてご連絡ください。

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-777-5536 (TTY: **711**).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-**888-777-5536** (TTY: **711**) पर कॉल करें।

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-888-777-5536** (መስማት ለተሳናቸው: **711**).

Farsi: **توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیری(TTY: **711**) **1-888-777-5536**

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-888-777-5536**- (رقم هاتف الصم والبكم: **711**).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-888-777-5536** (TTY: **711**).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-888-777-5536** (ATS : **711**).

Yoruba: AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o.
E pe ero ibanisoro yi **1-888-777-5536** (TTY: **711**).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-888-777-5536** (TTY: **711**).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-888-777-5536** (TTY: **711**).

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-888-777-5536** (TTY: **711**)।

Urdu: خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-888-777-5536** (TTY: **711**).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-888-777-5536** (TTY: **711**).

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-888-777-5536** (TTY: **711**).

Kaiser Permanente Medicare Plus Member Services

METHOD	Member Services – contact information
CALL	**1-888-777-5536** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Kaiser Permanente Member Services 2101 East Jefferson Street Rockville, Maryland 20852
WEBSITE	**kp.org**

State Health Insurance Assistance Program

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

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street Rockville, Maryland 20852

Amendment: "What You Need To Know" – Your Important Mandated Health Care Benefits and Rights and Other Legal Notices

For Kaiser Permanente Medicare Plus (Cost) Members

This amendment to the 2020 Evidence of Coverage (EOC) for Kaiser Permanente Medicare Plus (Cost) ("Plan") is effective October 1, 2019, through December 31, 2020, and contains your Maryland health care benefits and rights and important legal notices regarding the health care services provided thereunder to Kaiser Permanente Medicare Plus (Cost) members enrolled in the Plan.

The EOC is amended as follows:

1. Chapter 3: Using our plan's coverage for your medical services

a. Under Section 2.3 "How to get care from specialists and other network providers," the bullet titled, "Network specialty care" has been amended by adding a new second bullet:

- Your cost share will be calculated as if the provider rendering the covered services were a Plan Provider. The Non-Plan Provider will be reimbursed in accordance with §19-710.1 of the Health General Article of the annotated Code of Maryland.

2. Chapter 3: Using our plan's coverage for your medical services

a. Section 1.2 "Basic rules for getting your medical care covered by our plan" is amended to include:

Services Delivered Through Telemedicine. You may receive covered Services through telemedicine when the Service can be appropriately delivered using this mode of delivery. "Telemedicine" is the delivery of health care services, through the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a site other than the site at which the patient is located. Telemedicine is not audio only telephone conversation between the health care provider and a patient, electronic mail message between a health care provider and a patient or facsimile

transmission between a health care provider and a patient. Services delivered through telemedicine are subject to the same Cost-Sharing requirements as face-to-face Services, as shown in the Medical Benefits Chart in Chapter 4. of the *Evidence of Coverage.* Services delivered through telemedicine are subject to the referral process set forth in Section 2 of Chapter 3 ("Use providers in our network to get your medical care") of the *Evidence of Coverage*.

b. Section 3.1. The provision entitled "What is covered if you have a medical emergency?" is amended by adding the following additional language:

In those situations where Kaiser Permanente authorizes, directs, refers or otherwise allows you access to a hospital emergency facility or other urgent care facility, whether inside or outside the service area, for a medical condition that requires emergency surgery, we will reimburse the Physician, Oral Surgeon, Periodontist or Podiatrist who performed the surgical procedure for any follow-up care that is:

- medically necessary;
- directly related to the condition for which the surgical procedure was performed; and
- provided in consultation with you or your PCP.

The member's copayment and/or cost share for such follow-up care shall not exceed what the member is required to pay for services rendered by a physician, oral surgeon, periodontist, or podiatrist who is a member of the provider panel of the Health Plan.

3. Chapter 4: Medical benefits chart (what is covered and what you pay)

a. In addition to the benefits listed in the Benefits Chart in Chapter 4 of the EOC, the following benefits are included pursuant to state law. In the event of a conflict between the state-mandated benefit and the benefit provided under your EOC, the benefit that is most favorable to the member will apply.

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care † The Inpatient hospital care section of the EOC is amended to include the following two additional provisions: • Services arising from oral surgical, orthodontic, otologic, audiological, and speech/language treatment as a result of the congenital defect known as cleft lip, cleft palate or both.	Please refer to "Inpatient hospital care" in Chapter 4 of your EOC for applicable cost shares.

† Your provider must obtain prior authorization from our plan.

Services that are covered for you	**What you must pay** when you get these services
• We cover inpatient hospitalization services for a minimum stay of at least 48 hours following an uncomplicated vaginal delivery; and at least 96 hours following an uncomplicated cesarean section. Up to 4 days of additional hospitalization for the newborn are covered if the enrolled mother is required to remain hospitalized after childbirth for medical reasons.	
Inpatient hospital care† and home health agency care† following mastectomy The Inpatient hospital care section of the EOC is amended to include: For the purposes of this EOC, "mastectomy" means the surgical removal of all or part of a breast. You are covered for the cost of inpatient hospitalization services for a minimum of 48 hours following a mastectomy. You may request a shorter length of stay following a mastectomy if you decide, in consultation with your attending physician, that less time is needed for recovery. For a Member who remains in the hospital for at least 48 hours following mastectomy, you are covered for the cost of a home visit if prescribed by the attending physician. Refer to the Home Health Agency Care Benefit in this Amendment for home health visits covered following a mastectomy or removal of a testicle.	Please refer to "Inpatient hospital care" in Chapter 4 of your EOC for applicable cost shares.
Residential Crisis Services † You are covered for residential crisis services that are: • Provided to a Member with a mental illness who is experiencing or is at risk of psychiatric crisis that would impair the individual's ability to function in the community; • Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of an inpatient stay; • Provided out of the Member's residence on a short-	Please refer to "Inpatient mental health care" in Chapter 4 of your EOC for applicable cost shares.

† Your provider must obtain prior authorization from our plan.

Services that are covered for you	**What you must pay** when you get these services
term basis in a community-based residential setting; and • Provided by entities that are licensed by the Department of Health and Mental Hygiene to provide residential crisis services.	
Home Health Agency Care† Home Health Agency Care in Chapter 4 of your EOC is amended to include the following home visits: For women who remain in the hospital for at least 48 hours following mastectomy, covered services include the cost of a home visit if prescribed by the attending physician. For women who undergo a mastectomy; or for men who undergo removal of a testicle on an outpatient basis, or who receive less than 48 hours of inpatient hospitalization following the surgery, covered services include: • One home visit scheduled to occur within 24 hours following your discharge from the hospital or outpatient facility; and • One additional home visit, when prescribed by your attending physician. Following an obstetrical admission: We cover a home health visit for the enrolled mother and newborn if prescribed by the attending provider. In addition, HHA services are covered for an enrolled mother and her newborn child in the following situations: (a) if, in consultation with the mother's physician, the enrolled mother requests a shorter length of inpatient stay than 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated cesarean section, Health Plan will cover one home health visit to occur within 24 hours after discharge; and (b) if prescribed by the mother's attending physician, one additional home visit will be covered.	Please refer to the Home Health Agency Care section in Chapter 4 of your EOC for applicable cost shares. Home visits following an obstetrical admission are not subject to copayments, coinsurance, or deductibles, except for high-deductible health plans, which may be subject to deductibles.
Outpatient mental health care † Outpatient mental health care in Chapter 4 of your EOC	Please refer to "Outpatient mental

† Your provider must obtain prior authorization from our plan.

Services that are covered for you	**What you must pay** when you get these services
is amended to include the following services provided by a licensed or certified facility or program: • Psychological and neuropsychological testing for diagnostic purposes to treat mental illness, emotional disorders, drug abuse, and alcohol abuse.	health care" in Chapter 4 of your EOC for applicable cost shares.
Partial hospitalization services† Partial hospitalization is defined as the provision of medically directed intensive or intermediate short-term treatment for mental illness, emotional disorders, and drug and alcohol abuse for a period of less than twenty-four (24) hours but more than four (4) hours in a day in a licensed or certified facility or program. Partial hospitalization services in Chapter 4 of your EOC is amended to include: • Psychological and neuropsychological testing for diagnostic purposes to treat mental illness, emotional disorders, drug abuse, and alcohol abuse.	Please refer to "Partial hospitalization services* in Chapter 4 of your EOC for applicable cost shares.
Outpatient substance abuse services† Outpatient substance abuse services in Chapter 4 of your EOC is amended to include the following services provided by a licensed or certified facility or program: • Psychological and neuropsychological testing for diagnostic purposes to treat mental illness, emotional disorders, drug abuse and alcohol abuse. • Methadone maintenance treatment.	Please refer to "Outpatient substance abuse services" in Chapter 4 of your EOC for applicable testing cost shares. You pay 50% of the daily cost for methadone treatment.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers† The Outpatient surgery (including services provided at hospital facilities and ambulatory surgical centers) section of the EOC is amended to include: Services arising from oral surgical, orthodontic, otologic, audiological, and speech/language treatment as a result of the congenital defect known as cleft lip, cleft	Please refer to "Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers" in Chapter 4 of your EOC for applicable cost shares.

† Your provider must obtain prior authorization from our plan.

Services that are covered for you	**What you must pay** when you get these services
palate or both	
Durable Medical Equipment and related supplies† Durable Medical Equipment and related supplies in Chapter 4 of your EOC is amended to include: **Chemotherapy/Radiation therapy hair prosthesis** You are covered for one hair prosthesis for hair loss resulting from chemotherapy or radiation treatment for cancer. Coverage is limited to an allowance of up to $350.	You pay nothing on charges of up to $350, plus all balances on charges above Health Plan's maximum allowance amount of $350.
Artificial arms, legs and eyes, including components and repair You are covered for: • Artificial devices to replace, in whole or in part, a leg, an arm, or an eye; • Components of an artificial device to replace, in whole or in part, a leg, an arm, or an eye; and • Repairs to an artificial device to replace, in whole or in part, a leg, an arm, or an eye.	The member's cost share for replacements for legs, arms, or eyes and their components and repair will be the same as the member's cost share for primary care.
Hearing services † Hearing services in Chapter 4 of your EOC is amended to include: Hearing tests to determine the need for hearing correction, including newborn hearing screenings when ordered by a Plan Provider.	Please refer to "Hearing services" in Chapter 4 of your EOC for applicable cost shares.
Bone mass measurements Bone mass measurements in Chapter 4 of your EOC is amended to include: Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis is a covered service for a qualified individual when requested by a Plan Provider. A "qualified individual" means: • an estrogen deficient individual at clinical risk for osteoporosis; • an individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic	Please refer to "Bone mass measurement" in Chapter 4 of your EOC for applicable cost shares.

† Your provider must obtain prior authorization from our plan.

Services that are covered for you	**What you must pay** when you get these services
osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease; • an individual receiving long-term glucocorticoid (steroid) therapy; • an individual with primary hyperparathyroidism; or • an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.	
Colorectal cancer screening Colorectal cancer screening in Chapter 4 of your EOC is amended to include: • Colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society.	Please refer to "Colorectal cancer screening" in Chapter 4 of your EOC for applicable cost shares.
Breast cancer screening (mammograms) Breast cancer screening (mammograms) in Chapter 4 of your EOC is amended to include: • For all women, covered services also include breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society. • Digital tomosynthesis, commonly referred to as three-dimensional "3-D" mammography will be covered when the treating Plan physician determines that it is Medically Necessary.	Please refer to "Breast cancer screening (mammograms)" in Chapter 4 of your EOC for applicable cost shares.
Cervical and vaginal cancer screening Cervical and vaginal cancer screening in Chapter 4 of your EOC is amended to include: • For all women, covered services also includes Human Papillomavirus Screening (HPS at testing intervals recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists.	Please refer to "Cervical and vaginal cancer screening" in Chapter 4 of your EOC for applicable cost shares.

Services that are covered for you	**What you must pay** when you get these services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs Screening for sexually transmitted infections (STIs) and counseling to prevent STIs in Chapter 4 of your EOC is amended to include: **Chlamydia annual screening test** Annual Chlamydia screening for (a) women under the age of 20, if they are sexually active; (b) women 20 years of age or older, and men of any age, who have multiple risk factors, which include: (1) a prior history of sexually transmitted diseases; (2) new or multiple sex partners; (3) inconsistent use of barrier contraceptives; or (4) cervical ectopy.	Please refer to "Screening for sexually transmitted infections (STIs) and counseling to prevent STIs" in Chapter 4 of your EOC for applicable cost shares.
Prostate cancer screening exams Prostate cancer screening exams in Chapter 4 of your EOC is amended to replace the benefit in your EOC with the following benefit: For men who are between the ages of 40 and 75; when used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; when used for staging in determining the need for a bone scan in patients with prostate cancer; or when used for male patients who are at high risk of prostate cancer, covered services include the following: • Digital rectal exam • Prostate Specific Antigen (PSA) test • A medically recognized diagnostic examination	Please refer to "Prostate cancer screening exams" in Chapter 4 of your EOC for applicable cost shares.
Hearing Aids for Children Under Age 18 Chapter 4 of your EOC is amended to include: One hearing aid for each hearing impaired ear is a covered service every 36 months for children through the age of 17 if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist. You are covered for up to $1,400 per hearing aid. You may choose a hearing aid that is priced higher than the benefit and pay the difference between the price of the hearing aid and $1,400, without financial or contractual penalty to the provider of the hearing aid.	You pay nothing on charges up to $1,400 per hearing aid, plus you pay all balances on charges above the Health Plan's maximum allowance of $1,400 per hearing aid.

Services that are covered for you	**What you must pay** when you get these services
"Hearing aid" as the term is used above, is defined as a device that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children; and is non-disposable. The exclusion for "Hearing aids or exams to fit hearing aids exclusion" in Chapter 4 if included does not apply to this Hearing Aids for Children Under age 18 benefit.	
Morbid Obesity † We cover diagnosis and treatment of morbid obesity that is recognized by the National Institutes of Health and is consistent with guidelines approved by the National Institutes of Health. BMI means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms divided by height in meters squared. You must be at least 18 years of age or older and have either: • A body mass index (BMI) equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes; or • A BMI greater than 40 kilograms per meter squared **Note:** You will need to meet the above qualifications before your network provider will refer you to our bariatric surgery program. This program may refer you to other network providers to determine if you meet the additional criteria necessary for bariatric surgery, including nutritional, psychological, medical and social readiness for surgery. Final approval for surgical treatment will be required from the plan-designated physician.	Please refer to "Inpatient hospital care," "Outpatient surgery, including services provided at hospital facilities and ambulatory surgical centers," and/or "Physician/practitioner services, including doctor's office visits" in Chapter 4 of your EOC for applicable cost shares.
Medical Foods Medical Foods in Chapter 4 of your EOC is amended to include: Amino Acid-Based Elemental Formula, regardless of delivery method, is a covered service for the diagnosis and treatment of:	You pay 25% of our Allowance.

† Your provider must obtain prior authorization from our plan.

Services that are covered for you	**What you must pay** when you get these services
• Immunoglobulin E and non-Immunoglobulin E mediated allergies to multiple food proteins; • Severe food protein induced enterocolitis syndrome; • Eosinophilic disorders, as evidenced by the results of a biopsy; and • Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.	
Reconstructive Surgery† Reconstructive Surgery in Chapter 4 of your EOC is amended to include: Incident to a mastectomy, including all stages of reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast; and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.	Please refer to "Inpatient hospital care," "Outpatient surgery, including services provided at hospital facilities and ambulatory surgical centers," and/or "Physician/practitioner services, including doctor's office visits" in Chapter 4 of your EOC for applicable cost shares.
Clinical Trials Clinical Trials in Section 5 of Chapter 3 of your EOC is amended to include: You are covered for the costs you incur in a clinical trial as the result of treatment for a life-threatening condition; or prevention, early detection, and treatment studies on cancer. These clinical trials are a covered service if: 1. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer or any other life-threatening condition; 2. The treatment is being provided in a clinical trial approved by: • one of the National Institutes of Health (NIH) • an NIH cooperative group or an NIH center	Please refer to "Inpatient hospital care," "Outpatient surgery, including services provided at hospital facilities and ambulatory surgical centers," and/or "Physician/practitioner services, including doctor's office visits" in Chapter 4 of your EOC for applicable cost shares.

† Your provider must obtain prior authorization from our plan.

Services that are covered for you	**What you must pay** when you get these services
• the Food and Drug Administration (FDA) in the form of an investigational new drug application • the Federal Department of Veterans Affairs • an institutional review board of an institution in the state which has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the National Institutes of Health; 3. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise; 4. There is no clearly superior, non-investigational treatment alternative; and 5. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative. Coverage of your costs will not be restricted solely because you received the service outside the service area or because you received the service from a non-network provider. We also cover the costs you incur for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating your particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor or provider of that drug or device. This section may not be construed to affect compliance regarding coverage for off-label use of drugs.	
Habilitative Services for Children Under Age 19 We cover Medically Necessary Habilitative Services with no visit limits for children up until end of the month in which they turn age 19. Medically Necessary Habilitative Services are those Services and devices, including occupational therapy, physical therapy, and speech therapy that help a child keep, learn, or improve skills and functioning for daily living.	Please refer to "Physician/practitioner services, including doctor's office visits" in Chapter 4 of your EOC for applicable cost shares.

Services that are covered for you	**What you must pay** when you get these services
Medical Necessary Services to treat autism and autism spectrum disorders shall include Applied Behavioral Analysis (ABA). ***Habilitative Services Exclusions:*** • Services provided through federal, state or local early intervention programs, including school programs. • Services not preauthorized by the Health Plan.	
Infertility Services† Medically necessary services only. You are covered for the following infertility related services: Services and supplies for the diagnosis and treatment of involuntary infertility for women and men; • Artificial Insemination; and • In vitro fertilization, if: (a) For a Member whose spouse is of the opposite sex, the Member's oocytes are fertilized with the Member's spouse's sperm; unless i. The Spouse is unable to produce and deliver functional sperm; and the inability to produce and deliver functional sperm does not result from: (a) A vasectomy; or (b) Another method of voluntary sterilization. (b) the Member and the Member's spouse have a history of involuntary infertility, which may be demonstrated by a history of: i. if the Member and the Member's Spouse are of opposite sexes, intercourse of at least 2 years duration failing to result in pregnancy; or ii. if the Member and the Member's Spouse are of the same sex, six (6) attempts of artificial insemination over the course of 2 (two) years failing to result in pregnancy; or	Please refer to "Inpatient hospital care," "Outpatient surgery, including services provided at hospital facilities and ambulatory surgical centers" and "Physician/practitioner services, including doctor's office visits" in Chapter 4 of your EOC for applicable cost shares. **Related Prescription Drugs**: 50% Coinsurance

† Your provider must obtain prior authorization from our plan.

Services that are covered for you	**What you must pay** when you get these services
(c) or the infertility is associated with any of the following: i. endometriosis; ii. exposure in utero to diethylstilbestrol, commonly known as DES; iii. blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or iv. abnormal male factors, including oligospermia, contributing to the infertility; (d) the Member has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under this EOC; and (e) the in vitro fertilization procedures are performed at medical facilities that conform to applicable guideline or minimum standards issued by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine. • Intracytoplasmic Sperm Injection (ICSI) if the Member meets medical guidelines; and • Preimplantation Genetic Diagnosis (PGD) if the Member meets medical guidelines **Note**: Diagnostic procedures and drugs administered by or under the direct supervision of a Plan Provider are covered under this provision. **Infertility exclusions** • When the member does not meet the conditions of coverage as described in this Infertility Services section. • Infertility Services when the infertility is the result of an elective male or female sterilization surgical procedure. • The cost of donor semen, donor eggs, or donor embryos. • The cost of storage and thawing of fertilized eggs (embryos), female member's eggs and/or male member's sperm for future attempts.	

Services that are covered for you	**What you must pay** when you get these services
• Gamete intrafallopian transfers (GIFT). • Zygote intrafallopian transfers (ZIFT). **Infertility limitations** Covered services for in vitro fertilization embryo transfer cycles, including frozen embryo transfer (FET) procedure, is limited to three (3) attempts per live birth, not to exceed a maximum lifetime benefit of $100,000.	

Services that are covered for you	**What you must pay** when you get these services
Medicare Part B Prescription Drugs Oral chemo therapy drugs Specialty drugs Note: The statement pertaining to specialty drugs is not specific to oral chemotherapy drugs and applies to all specialty drugs within the Medicare Part B section.	 No charge Specialty drugs cost shares that are a coinsurance will not exceed $150 for a 30-day supply.
Ostomy Equipment and Supplies Prosthetic devices and related supplies† in Chapter 4 of your EOC is amended to include: Coverage for all medically appropriate and necessary equipment and supplies used for the treatment of ostomies, including flanges, collection bags, clamps, irrigation devices, sanitizing products, ostomy rings, ostomy belts, and catheters used for drainage of urostomies. The annual deductibles or coinsurance requirements may not be greater than the annual deductibles or coinsurance requirements for similar coverages.	Please refer to "**Prosthetic devices and related supplies**†" in Chapter 4 of your EOC for applicable cost shares.
Contraception medication refills Dispensing limit for prescribed contraceptives refills at Plan pharmacies or through the mail delivery program and coverage without a prescription for all contraceptive drugs, including devices approved by the U.S. Food and Drug Administration, and available by prescription and over the counter.	There is no copayment or coinsurance for up to a six-month supply per prescription except of therapeutically equivalent contraceptives.
Male sterilization	No charge
Fertility awareness-based methods Chapter 4 of your EOC is amended to include: Coverage for instruction by a licensed health care provider on fertility awareness–based methods, which are methods of identifying times of fertility and infertility by an individual to avoid pregnancy, including: • cervical mucous methods • sympto-thermal or sympto-hormonal methods	There is no coinsurance, copayment or deductible for fertility awareness-based methods.

† Your provider must obtain prior authorization from our plan.

Services that are covered for you	**What you must pay** when you get these services
• the standard days methods • and the lactational amenorrhea method	
Fertility preservation procedures for iatrogenic infertility† Chapter 4 of your EOC is amended to include: Coverage for standard fertility preservation procedures that are medically necessary to preserve fertility due to a need for medical treatment that may directly or indirectly cause iatrogenic infertility. **Definitions:** • **Iatrogenic infertility** means an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment affecting the reproductive organs or processes. • **Medical treatment that may directly or indirectly cause iatrogenic infertility** means medical treatment with a likely side effect of infertility as established by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologist, or the American Society of Clinical Oncology. • **Standard fertility preservation procedures** means procedures to preserve fertility that are consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologist, or the American Society of Clinical Oncology. Standard fertility preservation procedures include sperm and oocyte cryopreservation and evaluations, laboratory assessments, medications, and treatments associated with sperm and oocyte cryopreservation. **Standard fertility preservation procedures exclusion:** • Storage of sperm or oocytes.	Please refer to "Physician/practitioner services, including doctor's office visits†," "Outpatient diagnostic tests and therapeutic services and supplies†," and "Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers†" in Chapter 4 of your EOC for applicable cost shares. Related Prescription Drugs: 50% Coinsurance

† Your provider must obtain prior authorization from our plan.

Services that are covered for you	**What you must pay** when you get these services
Lymphedema† Chapter 4 of your EOC is amended to include: Coverage for medically necessary diagnosis, evaluation, and treatment of lymphedema, including: • Equipment; • Supplies; • Complex decongestive therapy; • Gradient compression garments; and • Self–management training and education. **Note**: A "gradient compression garment" means a garment that is used for the treatment of lymphedema, requires a prescription, and is custom fit for the individual for whom the garment is prescribed. **Exclusion:** • Disposable medical supplies, including over–the–counter compression or elastic knee–high or other stocking products.	Please refer to "Physician/practitioner services, including doctor's office visits," "Prosthetic devices and related supplies†," "Outpatient rehabilitation services†," and "Durable Medical Equipment†" in Chapter 4 of your EOC for applicable cost shares.
Diabetes equipment, supplies, and outpatient self-management training and educational services† Chapter 4 of your EOC is amended to include: Coverage for medically appropriate and necessary diabetes equipment, diabetes supplies, diabetes outpatient self-management training and educational services, including medical nutrition therapy to be provided through a program supervised by a licensed, registered, or certified health care provider for the treatment of: 1. Insulin-using diabetes; 2. Non-insulin using diabetes; 3. Elevated or impaired blood glucose levels induced by pregnancy, including gestational diabetes; or 4. Consistent with the American Diabetes Association's standards, elevated or impaired blood glucose levels induced by prediabetes.	Please refer to "Durable Medical Equipment†" and "Diabetes self-management training and diabetic services and supplies†" in Chapter 4 of your EOC for applicable cost shares.

† Your provider must obtain prior authorization from our plan.

4. Chapter 12, Definitions of important words of your Evidence of Coverage is amended by adding the following definitions:

Subscriber – An employee or member of the Group who is eligible to be covered under the Group's health plan as the primary insured, and not as a Dependent.

Dependent – An individual who is eligible to be covered under the Group's health plan as a dependent of a Subscriber.

Non-Participating Specialist Referrals – Benefits may be provided by non-participating specialists upon referral when: (1) You have been diagnosed by your Participating Dental Provider general dentist with a condition or disease that requires care from a dental specialist; (2) Kaiser Permanente and Dental Administrator do not have a Participating Dental Provider specialist who possesses the professional training and expertise to treat the member's condition or disease; or (3) Kaiser Permanente and Dental Administrator cannot provide reasonable access to a dental specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

Your cost share will be calculated as if the provider rendering the covered services were a Participating Dental Provider specialist. The non-participating specialist will be reimbursed in accordance with §19-710.1 of the Health General Article of the annotated Code of Maryland.

The above mandated health care benefits and rights and legal notice information are in addition to the benefits and terms of the member's 2020 EOC. All other EOC terms and conditions, medical care and services, Plan processes and policies, as described in the 2020 Kaiser Permanente Medicare Plus Evidence of Coverage, remain in full force and effect for the term January 1, 2020, through December 31, 2020.

KAISER FOUNDATION HEALTH PLAN
OF THE MID-ATLANTIC STATES, INC.

By: _____

Mark Ruszczyk
Vice President, Marketing, Sales & Business Development