Kaiser Foundation Health Plan, Inc.

This document is available for free in Spanish. Please contact Member Services number at **1-800-443-0815** for additional information. (TTY users should call **711**.) Hours are 8 a.m. to 8 p.m., 7 days a week.

*Este documento está disponible de manera gratuita en español. Para obtener información adicional, comuníquese con Servicio a los Miembros al **1-800-443-0815**. (Los usuarios de la línea TTY deben llamar al **711**). El horario es de 8 a. m. a 8 p. m., los 7 días de la semana.*

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

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Benefit Highlights

Accumulation Period

The Accumulation Period for this plan is 1/1/23 through 12/31/23 (calendar year).

Plan Out-of-Pocket Maximum

For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to the following amount:

For any one Member.....$1,000 per calendar year

Plan Deductible	None

Plan Provider Office Visits	**You Pay**
Most Primary Care Visits and most Non-Physician	

Introduction

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

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

This *Evidence of Coverage* ("*EOC*"*)* describes our Senior Advantage health care coverage provided under the *Group Agreement (Agreement)* between Health Plan (Kaiser Foundation Health Plan, Inc. ("Health Plan") and your Group (the entity with which Health Plan has entered into the Agreement).

This *EOC* is part of the Agreement between Health Plan and your Group. The *Agreement* contains additional terms such as Premiums, when coverage can change, the effective date of coverage, and the effective date of termination. The *Agreement* must be consulted to determine the exact terms of coverage. A copy of the *Agreement* is available from your Group.

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

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

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whether this *EOC* is still in effect and give you a current one if this *EOC* has been amended.

Definitions

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

Accumulation Period: A period of time no greater than 12 consecutive months for purposes of accumulating amounts toward any deductibles (if applicable) and out-of-pocket maximums. The Accumulation Period for this *EOC* is from 1/1/23 through 12/31/23.

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

Catastrophic Coverage Stage: The stage in the Part D drug benefit when you pay a low Copayment or Coinsurance for your Part D drugs after you or other qualified parties on your behalf have spent $7,400 in covered Part D drugs during the covered year. Note: This amount may change every January 1 in accord with Medicare requirements.

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

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

requirements, see “Who Is

Plan Facilities may change. If you have questions, please call Member Services.

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

Surrogacy Arrangement: An arrangement in which an individual agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the individual receives payment for being a surrogate. For the purposes of this *EOC*, "Surrogacy Arrangements" includes all types of surrogacy arrangements, including traditional surrogacy arrangements and gestational surrogacy arrangements.

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

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

benefit information, and to request a copy of the non-Medicare plan document.

If you are eligible to be a

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

If

Medicare card in a safe place. You may be asked to show it if you need hospice services or participate in routine research studies.

Getting Assistance

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your personal Plan Physician or

authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non–Plan Providers anywhere in the world. Be

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

Post-Stabilization Care

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

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

Before

Other Diagnostic and Treatment Services" in addition to the Cost Share for the Urgent Care evaluation

Note: If you receive Urgent Care in an Emergency Department, you pay the Cost Share for an Emergency Department visit as described under "Outpatient Care."

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Urgent Care from a Non–Plan Provider as described in this "Emergency

outpatient procedure). You may be asked to pay (or you

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

Plan Out-of-Pocket Maximum

There is a limit to the total amount of Cost Share you must pay under this *EOC* in the

For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:
If you need nonemergency, non–urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal condition, your cost for these services depends on whether you use a Plan Provider and follow plan rules (such as if there is a

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

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

Inpatient psychiatric hospitalization

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

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

For the following Services, refer to these sections

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

Opioid Treatment Program Services

please be aware it takes time for your prescriber to submit the necessary paperwork to be processed

In addition to

each month you use your Part D prescription drug coverage. The **Part D Explanation of Benefits** will tell you the total amount you, or others on your behalf, have spent on your prescription drugs and the total amount we have paid for your prescription drugs. A **Part D Explanation of Benefits** is also available

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

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

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

The references in the formulary to preferred generic and generic or brand-name drugs and specialty tier drugs do not apply to you. All the drugs in the formulary are covered the same without regard for whether they are generic, brand, or specialty tier drugs. Please note that sometimes a drug may appear more than once on our **2023 Comprehensive Formulary**. This is because different restrictions or cost-sharing may apply based on factors such

by Medicare" section and obtained at a Plan Pharmacy, you may be able to use approved manufacturer coupons as payment for the Cost Share that you owe, as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire amount of your Cost Share for your prescription. Certain health plan coverages are not eligible for coupons. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at **kp.org/rxcoupons**.

Drug utilization review

We conduct drug utilization reviews to make sure that you are getting safe and appropriate care. These reviews are especially important if you have more than one doctor who prescribes your medications. We conduct drug utilization reviews each time

supplies) are not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section (instead,

the applicable Cost Share for those other Services. For example, if laboratory tests or imaging Services ordered during a preventive office visit are not Preventive Services, you will pay the applicable Cost Share for those Services.

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

A Skilled Nursing Facility where your spouse is living at the time you leave the hospital

Substance Use Disorder Treatment

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

provide a prescription for eyeglass lenses: **a $10 Copayment per visit**

Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **a $10 Copayment per visit**

Non-Physician Specialist Visits to diagnose

Experimental or investigational Services

A Service is experimental or investigational if we, in consultation with the Medical Group, determine that one of the following is true:

- Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients)
- It requires government approval that has not been obtained when the Service is to be provided

Hair loss or growth treatment

Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

Surrogacy Arrangements

If you enter into a Surrogacy Arrangement and you or any other payee are entitled to receive payments or other compensation under the Surrogacy Arrangement, you must reimburse us for covered Services you receive related to conception, pregnancy, delivery, or postpartum care

any workers' compensation or employer's liability law

Requests for Payment

Requests for Payment of Covered Services or Part D drugs

If

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.

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

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

protect your personal health information as required by these laws.

Your “personal health information” includes the personal information you gave us when

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:

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- **To know about all of your choices.** 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.

What can you do if you believe you are being treated unfairly or your rights are not being

How

We will not

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 your 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. (F 1 0 0 -1 76.25 85.4919967DC BT 1 0 0 -1 126.53800201 13.0539999 Tm [ )]T7 0 0 -1 114.29199982 49.27300.

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 Review Organization. Later in this section, we talk about this

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

Your Part D Prescription Drugs: How to Ask

Guide to the Basics of Coverage Decisions and Appeals" section tells you how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf

If you want

Step-by-step: How to make a Level 2 Appeal

If we say ***no*** to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Organization reviews the decision we made when we said ***no*** to your first appeal. This organization decides whether the decision we made should be changed.

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

Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case

If we say ***no*** to your Level 1 Appeal, the written notice we send you will include instructions about how to make a Level 2 Appeal with the Independent Review Organization. These instructions will tell you who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization

When you make a Level 2 Appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." You

Step 3: If the dollar

hospital, and we think it is right (medically appropriate) for you to be discharged on that date. This written explanation is called the *Detailed Notice of Discharge*. You can get

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

The “Taking Your Appeal to Level 3 and Beyond” section tells you more about Levels 3, 4, and 5 of the appeals process

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

You can appeal to us

Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions,

legal way to request a change to our coverage decision about when to stop your care. “Step-by-step: How to make a Level 1 Appeal to

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

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 the “Important Phone Numbers and Resources” section 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

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coverage and Premiums may change, and where to send your Premium payments.

As described in "Conversion from Group Membership to an Individual Plan" in this "Continuation of Membership" section, you may be able to convert to an individual (nongroup) plan if you don't apply for COBRA coverage, or if you enroll in COBRA and your COBRA coverage ends.

Coverage for a disabling condition

If you became Totally Disabled while you were a Member under your Group's *Agreement* with us and while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates and is not renewed, we will cover Services for your totally disabling condition until the earliest of the following events occurs:

- 12 months have elapsed since your Group's *Agreement*

Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course

for notifying us of any change in address. Subscribers who move should call Member Services and Social Security toll free at **1-800-772-1213** (TTY users call **1-800-325-0778**) as soon as possible to give us their new address. If a Member does not reside with the Subscriber, or needs to have

Coverage decisions, appeals, or complaints for Services – contact information

Call 1-800-443-0815

involve coverage or payment disputes. (If your problem is about our plan's coverage or payment, you should look at the section above about requesting coverage decisions or making appeals.) For more information about making a complaint about your Part D prescription drugs, see the "Coverage Decisions, Appeals, and Complaints" section.

Complaints for Part D prescription drugs – contact

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 California, the Quality Improvement Organization is called

Specified Low-Income Medicare Beneficiary (SLMB): Helps pay Part B premiums. Some people

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Korean:

. 1-800-443-0815
(TTY 711) . .
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Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-443-0815 (TTY 711).