KAISER PERMANENTE®

All Plans offered and underwritten by
Kaiser Foundation Health Plan of the Northwest

January 18, 2024

Tami Mahrt
Multnomah County Employees
Employee Benefits
501 Se Hawthorne Blvd Ste 400
Portland, OR 97214

Group number: 1569-452

Dear Tami,

Thank you for selecting Kaiser Permanente for your group's health care needs.

Enclosed is the Senior Advantage with Part D Plan *Group Agreement* effective 01/01/2024 through 12/31/2024 for Multnomah County Employees. The *Group Agreement* includes group contract provisions, such as monthly Premium amounts, and incorporates the *Evidence of Coverage (EOC),* which is the member portion of the contract. The *EOC* explains benefits and cost share amounts, limitations, exclusions, and other information to help the member understand their plan.

Also enclosed is a *Summary of Changes and Clarifications*. Please review this to learn about changes to the *Group Agreement* for this year.

We know you have a choice of health plans, and we appreciate your business. If you have any questions about this *Group Agreement* or your health plan, please contact Lilian Belaen at (971) 284-0844.

Sincerely,

Kaiser Permanente Sales & Account Management Team
Enclosures

Kaiser Permanente Building
500 N.E. Multnomah Street, Suite 100
Portland, OR 97232-2099

KAISER PERMANENTE®

2024 *Group Agreement* and *Evidence of Coverage* Summary of Changes and Clarifications for Oregon Large Employer Groups

This is a summary of changes and clarifications that we made to your *Group Agreement* for the 2024 plan year. The *Group Agreement* includes the *Evidence of Coverage* (*EOC*), *Benefit Summary*, and any applicable notices, riders, and endorsement documents. This summary does not include minor changes and clarifications we are making to improve the readability and accuracy of the *Group Agreement*, or changes that may occur throughout the remainder of the plan year as a result of federal or state mandates.

Other plan-specific or product-specific benefit changes, including changes to deductible, copayment, or coinsurance amounts, may apply to your plan. Please refer to the 2024 renewal proposal and/or confirmation for your group and the 2024 Oregon Plan Changes brochure for information about these types of changes.

This Summary of Changes and Clarifications supplements the information contained in your *Group Agreement*. In the event of conflict between this summary and the *Group Agreement*, the *Group Agreement* shall control. Unless another date is listed, the changes described in this summary are effective when your *Group Agreement* renews in 2024. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

Changes and Clarifications that Apply to Medical Plans

These changes apply to Kaiser Permanente's commercial (non-Medicare) group plans. Changes to our Senior Advantage plans may be found at the end of this summary.

Benefit Changes

- **Diagnostic Breast Imaging**. In accordance with OR Senate Bill 1041, we added language in the "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" section of the *EOC* and the *Benefit Summary*, indicating that services for diagnostic and supplemental breast imaging are provided at $0 cost share, after Deductible only for high-deductible plans.
- **Kaiser Permanente at Home™**. We expanded Kaiser Permanente at Home™ coverage to High Deductible plans. This program provides care in a Member's home as an alternative to receiving acute care in a hospital. Services include home visits by healthcare professionals, communication devices, and medically necessary supplies and equipment.
- **Primary Care Access**. In accordance with OR Senate Bill 1529, we modified the *Benefit Summary* to reflect that the first three primary care related visits per year will have a $5 cost share, except for plans that have a $0 cost share or telemedicine services which will stay at $0 cost share. The first three visits are any combination of in-person or telemedicine services for: primary care non-specialty medical visits, behavioral health outpatient services, naturopathic medicine visits, or substance use disorder outpatient services. Additionally, we consolidated the rows in the "Telemedicine Services" section, since the cost share is the same for telephone visits, video visits, and e-visits.

Benefit Clarifications

- **Ambulance Services**. In the Kaiser Permanente Plus™ *Benefit Summary,* we changed the "Per emergency transport" row to "Per transport" for clarity.

- **First Fill Drug or Supply**. Throughout the Kaiser Permanente Plus™ *EOC,* we replaced references of "Kaiser Permanente Pharmacy" with "Participating Pharmacy" for clarity. Additionally, in the "Limited Outpatient Prescription Drugs and Supplies" section, we added language indicating Members are entitled to a first fill of a drug or supply at any Participating Pharmacy and that those providers, while not Kaiser Permanente Pharmacies, are not considered Out-of-Network.
- **Gender Affirming Treatment**. In accordance with OR House Bill 2002, we updated the definition of gender affirming treatment in the "Definitions" section of the *EOC*.
- **Hearing Aids for Dependents**. We revised and restructured the "Hearing Aids and Other Hearing Devices for Dependents" section of the *EOC* and *Benefit Summary* to include the new provisions and changes outlined in OR House Bill 2994. We also made changes to improve the readability and flow of the section. Some of these changes include:
  - Renaming the section from "Hearing Aid Services for Dependents" to "Hearing Aids and Other Hearing Devices for Dependents."
  - Changing the term "hearing assistive technology systems" to "assistive listening devices" to align with bill terminology updates.
  - Adding new language to the *EOC* on fitting and reprogramming limitations and requirements.
  - Revising up the "Hearing Aids" subsection of the *EOC* to more clearly describe the coverage for different types of hearing devices.
  - Revising the *Benefit Summary* in accordance with the new provision that requires hearing aids, assistive listening devices, and associated exams to no longer be subject to the deductible, except in High Deductible plans.
- **Infertility to Fertility Changes.** Throughout the *EOC,* we changed the term "infertility" to "fertility" to be more inclusive in the application of the benefit. Additional edits were made to the "Fertility Services" section to provide more detail around coverage, along with modifications to exhibit more inclusive, gender-neutral language.
- **Naturopathic Medicine**. We added language to the "Naturopathic Medicine" section of the *EOC* to clarify that The CHP Group is the network we contract with as Participating Providers for Traditional, Deductible, High Deductible, and Kaiser Permanente Plus™ plans, and as Select Providers for Added Choice® plans. Additionally, for Dual Choice PPO™ plans, we deleted redundant language defining an In-Network Provider as this is covered in the "Definitions" section.
- **Non-Prescription Hearing Aid Exclusion**. In the "Hearing Aids and Other Hearing Devices for Dependents" section of the *EOC*, we added an exclusion to clarify that we do not cover non-prescription over-the-counter hearing aids.
- **Rehabilitative Therapy Services**. In the "Rehabilitative Therapy Services" section of the Added Choice®, PPO Plus, and Dual Choice PPO™ *EOC*, we made several format and language updates for better alignment and consistency.
- **Repair and Replacement of Prosthetic and Orthotic Devices**. In accordance with OR SB 797, we revised the "External Prosthetic Devices and Orthotic Devices" section of the *EOC* to clarify that we cover repair and replacement of Medically Necessary prosthetic and orthotic devices.
- **Skilled Nursing**. In the "Skilled Nursing Facility Services" section of the Dual Choice PPO™, PPO Plus, and Added Choice® *EOC*, we made several format and language updates, including removing the "Skilled Nursing Facility Limitations" section, for better alignment and consistency.

Other Changes or Clarifications

- **"About Kaiser Permanente" Section Changes.** In the Traditional, Deductible, and High Deductible plans, we deleted the "About Kaiser Permanente" section and moved important content to other sections of the *EOC*, including the "How to Obtain Services" section and the "Introduction" section. This change improves readability by placing the key information in more relevant sections.
- **Cigna Network**. In Added Choice®, Dual Choice PPO™, and PPO Plus the Cigna PPO network is replacing the First Choice Health network and First Health Network outside of Oregon and other states where Kaiser Permanente operates. Inside Oregon and other states where Kaiser Permanente operates, there is no provider network change. We modified the *EOC* in several locations to support the Cigna PPO network change.
- **Local Member Services**. Member Services representatives are no longer present onsite at Kaiser Permanente facilities and medical offices, so we removed language about onsite administrative offices from the *EOC*.
- **Member Relations Updates**. Due to an administrative change, we updated the contact information under the "Non-Urgent Pre-service Claim" and "Non-Urgent Concurrent Care Claim" sections of the *EOC*.
- **Member Service/Customer Service**. We removed instances of the Member Services/Customer Service phone number throughout the body of the *EOC*. The phone number is still listed on the *EOC* cover as well as in the "Getting Assistance" section.
- **Member Services changed to Customer Service**. We changed references of "Member Services" to "Customer Service" in the Added Choice® and PPO Plus plan documents for consistency across products, ID cards, and marketing collateral.
- **Mental Health to Behavioral Health**. In accordance with Oregon Rulemaking around Behavioral Health Parity rules, we made the following changes to our documents:
  - Added a definition of "Behavioral Health Condition" in the *EOC*.
  - Adjusted the definition of "Behavioral Health Assessment" in the *EOC*.
  - Changed the term "mental health" to "behavioral health" where appropriate throughout the Prescription Drug Rider, *EOC*, and *Benefit Summary*, and reordered benefit sections accordingly.
- **Referrals**. In the Added Choice® and PPO Plus *EOC,* the "When Referrals Are Required" section was renamed to "Referrals" for consistency across products.
- **Transparency in Coverage**. We added a "Nonduplication Agreement" provision in the *Group Agreement* to explain what we do to satisfy the Group's regulatory requirements under the HR 133 Consolidated Appropriations Act.
- **URL Changes**. In the Added Choice®, Dual Choice PPO™, and PPO Plus *EOCs*, we changed the product specific URLs in the to the more general **kp.org/choiceproducts/nw** landing page to improve the navigation experience and match the ID cards and other marketing materials.

Changes and Clarifications that Apply to Medical Benefit Riders

Benefit Changes

- **HIV Post-Exposure Prophylaxis (PEP) Drugs**. In compliance with OR House Bill 2574, we added a line in the "Outpatient Prescription Drug Rider" *Benefit Summary* for HIV post-exposure prophylaxis

(PEP) drugs, which are required to be covered at $0 cost share, subject to Deductible only in High Deductible plans.

Benefit Clarifications

- **Adult Vision Hardware and Optical Services Rider**. We added language to the "Adult Vision Hardware and Optical Services Rider" to clarify that limits are combined across all providers who may provide covered services for Added Choice® and PPO Plus plans. For Kaiser Permanente Plus™ plans, we clarified that Members pay the In-Network cost share for covered services from Participating Providers, and we added a column to the rider *Benefit Summary* table showing that this benefit is not covered Out-of-Network.
- **Alternative Care Services Rider**. We added language to the "Alternative Care Services Rider" to clarify that The CHP Group is the network we contract with as Participating Providers for Traditional, Deductible, High Deductible, and Kaiser Permanente Plus™ plans; and as Select Providers for Added Choice® plans. Additionally, we removed redundant language defined Participating Providers for Traditional, Deductible, High Deductible, and Kaiser Permanente Plus™ plans; Select Providers for Added Choice® plans; and In-Network Providers for Dual Choice PPO™ plans.
- **Alternative Care Services Rider**. When this rider includes a benefit maximum, we added language to clarify that the Member is responsible for paying the full amount for services after the benefit maximum is reached for Traditional, Deductible, High Deductible, Added Choice®, and PPO Plus plans. For Kaiser Permanente Plus™ plans, we clarified that Members pay the In-Network cost share for covered services from Participating Providers, and we added a column to the rider *Benefit Summary* table showing that this benefit is not covered Out-of-Network.
- **Drug Manufacturer Coupons**. In the "Cost Share for Covered Drugs and Supplies" section of the "Outpatient Prescription Drug Rider" for High Deductible plans, we modified the drug manufacturer coupon paragraph to replace "Cost Share" with "Copayment or Coinsurance" and we added a new sentence to clarify that drug manufacturer coupons cannot be used towards the payment of the plan Deducible. Both changes were made to clarify how the drug manufacturer coupons work in HSA-compatible High Deductible health plans.
- **Eyeglasses or Contact Lenses After Cataract Surgery**. We modified the "Adult Vision Hardware and Optical Services Rider" and "Pediatric Vision Hardware and Optical Services Rider" for Added Choice® and PPO Plus plans to clarify that if a Member obtains eyeglasses or contact lenses after cataract surgery from a Non-Participating Provider, we will pay the amount we would have covered had they obtained the eyeglasses or contact lenses from a Select provider (Added Choice®) or PPO Provider (PPO Plus), and the Member will be responsible for the difference.
- **Fertility Treatment Services**. In the Kaiser Permanente Plus™ plan "Fertility Treatment Services Rider," we clarified that Members pay the In-Network cost share for covered services from Participating Providers, and we added a column to the rider *Benefit Summary* table showing Fertility Treatment is not covered Out-of-Network.
- **First Fill Drug or Supply**. Throughout the Kaiser Permanente Plus™ "Outpatient Prescription Drug Rider," we replaced references to "Kaiser Permanente Pharmacy" with "Participating Pharmacy" for clarity. Additionally, in the "At Participating Pharmacies" section we added language indicating Members are entitled to a first fill of a drug or supply at any Participating Pharmacy and that those providers, while not Kaiser Permanente Pharmacies, are not considered Out-of-Network.
- **Hearing Aid Rider**. We added language to the Added Choice®, PPO Plus, and Dual Choice PPO™ "Hearing Aid Rider" to clarify that benefit limits are combined across all providers who may provide

covered services. Additionally, for Dual Choice PPO™ plans, we added language to clarify that the allowance amount is also combined for all providers. For Kaiser Permanente Plus™ plans, we clarified that Members pay the In-Network cost share for covered services from Participating Providers, and we added a column to the rider *Benefit Summary* table showing that this benefit is not covered Out-of-Network.

- **Non-Prescription Hearing Aid Exclusion**. We added an exclusion to the "Hearing Aid Rider" to clarify that we do not cover non-prescription over-the-counter hearing aids.
- **Pediatric Vision Hardware and Optical Services Rider**. For Kaiser Permanente Plus™ plans, we clarified that Members pay the In-Network cost share for covered services from Participating Providers, and we added a column to the rider *Benefit Summary* table showing that this benefit is not covered Out-of-Network.

Other Changes or Clarifications

- **Infertility to Fertility Changes.** We changed the term "infertility" to "fertility" throughout the "Fertility Treatment Services Rider" to be more inclusive in the application of the benefit.

Changes and Clarifications that Apply to Dental Plans

Benefit Clarifications

- **Dental Office Visit.** In the Traditional Dental plan *Benefit Summary,* under the "Dental Office Visit" row, we added language to clarify that a dental office visit cost share amount is in addition to the cost share for Services provided during the visit.
- **Exclusions and Limitations for Full Mouth Reconstruction.** In the "Exclusions and Limitations" section, we enhanced the language around full mouth reconstruction exclusions for added benefit clarity.
- **No-Fault Insurance.** We modified the language in the "Injuries and Illnesses Alleged to be Caused by Other Parties or Covered by No-Fault Insurance" section of the *EOC* to add detail around no-fault insurance.
- **Workers' Compensation or Employer's Liability.** We simplified the language in the "Workers' Compensation or Employer's Liability" section of the *EOC* to explain that we will provide covered services even if it is unclear whether the Member is entitled to a payment or settlement.

Other Changes or Clarifications

- **Member Relations Updates**. Due to an administrative change, we updated the contact information in the "Non-Urgent Concurrent Care Claim" section of the *EOC*.
- **Post-Service Claims Address**. In the "Post-Service Claims – Services Already Received" section of the Traditional Dental *EOC*, we updated the address where Members can send dental claims for services they received from Non-Participating Providers without a referral.

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Changes and Clarifications that Apply to Senior Advantage Plans

Benefit Changes or Clarifications

- **Colorectal Cancer Screening.** We added criteria to clarify the benefit frequency for various screening tests based on age and risk factors.
- **Fitness Benefit (the Silver&Fit® Healthy Aging and Exercise Program).** We updated the list of Silver&Fit services to include a new Home Fitness Kit for Walking/Trekking.
- **Outpatient Mental Health Care.** We updated the list of provider types that can provide covered services under this benefit to include licensed professional counselors (LPCs) and licensed marriage and family therapists (LMFTs).
- **Real-Time Benefit Tool.** For groups with Part D coverage, we added information about this tool that allows Members to search for drugs on the "Drug List" to see an estimate of what they will pay, and if there are alternative drugs on the "Drug List" that could treat the same condition.
- **Urgently Needed Services.** We added more detail to clarify that cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation

Portland, Oregon

Large Group Senior Advantage Plan with Part D Group Agreement

Group Name: Multnomah County Employees

Group Number: 1569 – 452

Term of *Agreement*

01/01/2024, through 12/31/2024

Anniversary date

January 1

Authorized representative

TABLE OF CONTENTS

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST

A Nonprofit Corporation

Group Agreement

INTRODUCTION

This *Group Agreement (Agreement)*, including the Large Group Senior Advantage *Evidence of Coverage (EOC)* incorporated herein by reference, and any amendments, constitutes the contract between Kaiser Foundation Health Plan of the Northwest (Health Plan) and Multnomah County Employees (Group). In this *Agreement,* some capitalized terms have special meaning; please see the "Definitions" section in the *EOC* document for terms you should know.

To be eligible under this *Agreement,* the Group must meet the underwriting requirements set forth in Health Plan's Rate Assumptions and Requirements document.

PREMIUM

Only Members for whom Health Plan has received the appropriate Premium payment listed below are entitled to coverage under this *Agreement,* and then only for the period for which Health Plan has received appropriate payment.

Monthly Payments

Monthly Premium Amounts

Medicare as Primary Payer

For each Member eligible for benefits under Part A, enrolled in Part B, and eligible for Part D of Medicare who has enrolled in Kaiser Permanente Senior Advantage with Part D: $427.08

Medicare as Secondary Payer

Members who are eligible and enrolled in Medicare Part A or B and for whom Medicare is secondary payer are subject to the same Premium amounts and receive the same benefits as Members who are not eligible for Medicare. Members who are eligible and enrolled in Medicare Parts A and B as secondary payer and who meet applicable eligibility requirements may also enroll in a Kaiser Permanente Senior Advantage plan. These Members receive the coverages described in both the non-Medicare plan and the Senior Advantage plan, and the Premium amounts for these Members are the Premium amounts for the non-Medicare plan.

For each Member eligible for benefits under Part A, enrolled in Part B, and eligible for Part D of Medicare who has enrolled in Kaiser Permanente Senior Advantage with Part D: $951.72

TERM OF *AGREEMENT*, ACCEPTANCE OF *AGREEMENT*, AND RENEWAL

Term of *Agreement*

Unless terminated as set forth in the "Termination of *Agreement"* section, this *Agreement* is effective for the term shown on the cover page.

Acceptance of *Agreement*

Group will be deemed as having accepted this *Agreement* and any amendments issued during the term of this *Agreement.*

Group may not change this *Agreement* by adding or deleting words, and any such addition or deletion is void. If Group wishes to change anything in this *Agreement,* Group must contact its Health Plan account manager. Health Plan might not respond to any changes or comments that Group may submit. Group may not construe Health Plan's lack of response to any submitted changes or comments to imply acceptance. Health Plan will issue a new agreement or amendment if Health Plan and Group agree on any changes.

Renewal

This *Agreement* is guaranteed renewable, but does not automatically renew. If Group complies with all of the terms of this *Agreement,* Health Plan will offer to renew this *Agreement,* upon not less than 30 days prior written notice to Group, either by sending Group a new group agreement to become effective immediately after termination of this *Agreement*, or by extending the term of this *Agreement* pursuant to "Amendments Effective on Anniversary Date" in the "Amendment of *Agreement"* section. The new or extended group agreement will include a new term of agreement and other changes. If Group does not renew this *Agreement,* Group must give Health Plan written notice as described under "Termination on Notice" in the "Termination of *Agreement"* section.

AMENDMENT OF *AGREEMENT*

Amendments Effective on Anniversary Date

Upon not less than 30 days prior written notice to Group, Health Plan may extend the term of this *Agreement* and make other changes by amending this *Agreement* effective on the anniversary date of any year (see cover page for anniversary date).

Amendment due to Tax or Other Charges

If during the term of this *Agreement* a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Health Plan, Medical Group, or Kaiser Foundation Hospitals or upon any activity of any of them, then upon 31 days prior written notice, Health Plan may increase Group's Premium to include Group's share of the new or increased tax or charge.

Amendment Due to Medicare Changes

Health Plan contracts on a calendar year basis with the Centers for Medicare and Medicaid Services to offer Kaiser Permanente Senior Advantage. Health Plan may amend this *Agreement* to change any Senior Advantage *EOCs* and Premiums effective January 1 of any year (unless the federal government requires or allows a different effective date). The amendment may include an increase or decrease in Premiums and benefits (including Member cost sharing and the Medicare Part D initial and catastrophic coverage levels). Health Plan will give Group written notice of any such amendment.

Other Amendments

Health Plan may amend this *Agreement* at any time by giving written notice to Group, in order to (a) address any law or regulatory requirement; (b) reduce or expand the Health Plan Service Area; or (c) increase any benefits of any Medicare product approved by the Centers for Medicare and Medicaid Services (CMS), if applicable to this *Agreement.*

TERMINATION OF *AGREEMENT*

This *Agreement* will terminate under any of the conditions listed in this "Termination of *Agreement*" section. All rights to benefits under this *Agreement* end at 11:59 p.m. PST on the termination date, except as expressly provided in the "Ending your membership in our plan" section of the *EOC*.

If this *Agreement* terminates and Group does not replace this coverage with another plan, Health Plan will give Group written notice of termination not later than 10 working days after the termination date and will explain the rights of Members regarding continuation of coverage as provided by federal and state law.

If Health Plan fails to give notice as required, this *Agreement* shall continue in effect from the date notice should have been given until the date the Group receives the notice. Health Plan will waive the Premium for the period for which coverage is continued and the time period within which Member may exercise any right to continuation shall commence on the date that Group receives the notice. Health Plan will properly notify Members of their right to continuation of coverage under federal and state law.

Termination on Notice

Group may terminate this *Agreement* by giving prior written notice to Health Plan not less than 30 days prior to the termination date and remitting all amounts payable relating to this *Agreement,* including Premium, for the period through the termination date.

Termination for Fraud

Health Plan may terminate this *Agreement* by giving at least 30 days prior written notice to Group, if Group commits fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan. For example, an intentional misrepresentation of material fact occurs if Group intentionally furnishes incorrect or incomplete material information to Health Plan or is aware that incorrect or incomplete material information has been provided to Health Plan on enrollment or other Health Plan forms.

Termination for Violation of Contribution or Participation Requirements

Health Plan may terminate this *Agreement* upon 31 days prior written notice to Group, if Group fails to comply with Health Plan's contribution or participation requirements (including those listed in the "Contribution and Participation Requirements" section).

Termination for Discontinuance of a Product or all Products within a Market

Health Plan may terminate a particular product or all products offered in the group market as permitted by law.

Health Plan may terminate this *Agreement* if it ceases to write new business in the group market in Oregon or in a specific service area within Oregon, or elects not to renew all of its group plans in Oregon or in a specific service area within Oregon, or both cease offering and cease renewing all products in Oregon or a specific service area in Oregon, if Health Plan fails to reach an agreement with health care providers. To discontinue all products, Health Plan must: (a) notify the Director of the Department of Consumer and Business Services and all Groups; and (b) not cancel coverage for 180 days after the date of notice to the Director and Groups.

Health Plan may terminate this *Agreement* if it elects not to offer or renew, or offer and renew, this type of plan in Oregon or within a specific service area within Oregon. Except as provided below regarding failure to reach agreement with providers, in order to discontinue a product, Health Plan must: (a) cease to offer and/or cease to renew this plan for all groups; (b) offer (in writing) to each group covered by this plan, enrollment in any other plan offered by Health Plan in the group market, not less than 90 days prior to discontinuance; and (c) act uniformly without regard to claims experience of affected groups or the health status of any current or prospective Member.

Health Plan may terminate this *Agreement* if the Director of the Department of Consumer and Business Services orders Health Plan to discontinue coverage upon finding that continuation of coverage (a) would not be in the best interests of the Members; or (b) would impair Health Plan's ability to meet its contractual obligations.

Health Plan may terminate this *Agreement* by providing not less than 90 days prior written notice if there are no Members covered under this *Agreement* who reside or work in the Service Area.

Health Plan may terminate this *Agreement* if it is unable to reach an agreement with the health care providers to provide Services within a specific service area. Health Plan must: (a) cease to offer and cease to renew this plan for all groups within the service area; and (b) not less than 90 days prior to discontinuance, notify the Director of the Department of Consumer and Business Services and each group in that service area of the decision to discontinue offering the plan(s) and offer all other group plans available in that service area.

CONTRIBUTION AND PARTICIPATION REQUIREMENTS

No change in Group's contribution or participation requirements is effective for purposes of this *Agreement* unless Health Plan consents in writing.

Group must:

- Meet all underwriting requirements set forth in Health Plan's Rate Assumptions and Requirements document.
- With respect to all persons entitled to coverage under Group's plan(s), offer enrollment in Health Plan to all such persons on conditions no less favorable than those for any other plan available through Group.
- Permit Health Plan to examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement.*
- Comply with Centers for Medicare and Medicaid Services (CMS) requirements governing enrollment in, and disenrollment from, Kaiser Permanente Senior Advantage.

SUBSCRIBER CONTRIBUTIONS FOR MEDICARE PART C AND PART D COVERAGE

Medicare Part C Coverage

This "Subscriber Contributions for Medicare Part C Coverage" section applies to Group's Kaiser Permanente Senior Advantage coverage. Group's Senior Advantage Premiums include the Medicare Part C premium for coverage of items and services covered under Parts A and B of Medicare, and supplemental benefits. Group may determine how much it will require Subscribers to contribute toward the Medicare Part C premium for each Senior Advantage Member in the Subscriber's Family, subject to the following restrictions:

- If Group requires different contribution amounts for different classes of Senior Advantage Members for the Medicare Part C premium, then Group agrees to the following:
    - Any such differences in classes of Members are reasonable and based on objective business criteria, such as years of service, business location, and job category.
    - Group will not require different Subscriber contributions toward the Medicare Part C premium for Members within the same class.
- Group will not require Subscribers to pay a contribution for Medicare Part C coverage for a Senior Advantage Member that exceeds the Medicare Part C premium for items and services covered under Parts A and B of Medicare, and supplemental benefits. As applicable, Health Plan will pass through monthly payments received from CMS (the monthly payments described in 42 C.F.R. 422.304(a)) to reduce the amount the Member contributes toward the Medicare Part C premium.

Medicare Part D Coverage

This "Subscriber Contributions for Medicare Part D Coverage" section applies only to Group's Kaiser Permanente Senior Advantage coverage that includes Medicare Part D prescription drug coverage. Group's Senior Advantage monthly Premium includes the Medicare Part D premium. Group may determine how much it will require subscribers to contribute toward the Medicare Part D premium for each Senior Advantage Member in the Subscriber's Family, subject to the following restrictions:

- If Group requires different contribution amounts for different classes of Senior Advantage Members for the Medicare Part D premium, then Group agrees to the following:
    - Any such differences in classes of Members are reasonable and based on objective business criteria, such as years of service, business location, and job category, and are not based on eligibility for the Medicare Part D Low Income Subsidy (the subsidies described in 42 C.F.R. Section 423 Subpart P, which are offered by the Medicare program to certain low-income Medicare beneficiaries enrolled in Medicare Part D, and which reduce the Medicare beneficiaries' Medicare Part D premiums and/or Medicare Part D cost-sharing amounts).
    - Group will not require different subscriber contributions toward the Medicare Part D premium for Members within the same class.
- Group will not require subscribers to pay a contribution for prescription drug coverage for a Senior Advantage Member that exceeds the Premium for prescription drug coverage (including the Medicare Part D premium). The Group will pass through direct subsidy payments received from CMS to reduce the amount the Member contributes toward the Medicare Part D premium.

- Health Plan will credit Group with any Low Income Subsidy amounts that Health Plan receives from CMS for Group's Members and Health Plan will identify those Members for Group as required by CMS. For those Members, Group will first credit the Low Income Subsidy amount toward the Subscriber's contribution for that Member's Senior Advantage Premium for the same month, and will then apply any remaining portion of the Member's Low Income Subsidy toward the portion of the Senior Advantage Premium that is paid on behalf of that Member for that month. If Group is unable to reduce the Subscriber's contribution before the Subscriber makes the contribution, Group shall, consistent with CMS guidance, refund the Low Income Subsidy amount to the Subscriber (up to the amount of the Subscriber Premium contribution for the Member for that month) within 45 days after the date Health Plan receives the Low Income Subsidy amount from CMS. Health Plan reserves the right to periodically require Group to certify that Group is either reducing Subscribers' monthly Premium contributions or refunding the Low Income Subsidy amounts to Subscribers in accord with CMS guidance.
- For any Members who are eligible for the Low Income Subsidy, if the amount of that Low Income Subsidy is less than the Member's contribution for the Medicare Part D premium, then Group should inform the Member of the financial consequences of the Member's enrolling in the Member's current coverage, as compared to enrolling in another Part D plan with a Premium equal to or less than the Low Income Subsidy amount.

Late enrollment penalty. If any Members are subject to the Medicare Part D late enrollment penalty, Premiums for those Members will increase to include the amount of the penalty.

MISCELLANEOUS PROVISIONS

Administration of *Agreement*

Health Plan may adopt policies, procedures, rules, and interpretations to promote efficient administration of this *Agreement.*

Assignment

Health Plan may assign this *Agreement.* Group may not assign this *Agreement* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Health Plan's prior written consent. This *Agreement* shall be binding on the successors and permitted assignees of Health Plan and Group.

Attorney Fees and Costs

If Health Plan or Group institutes legal action against the other to collect any sums owed under this *Agreement,* the party that substantially prevails will be reimbursed for its reasonable costs of collection, including attorneys' fees, by the other party.

Governing Law

Except as preempted by federal law, this *Agreement* will be governed in accord with Oregon law and any provision that is required to be in this *Agreement* by state or federal law shall bind Group and Health Plan regardless of whether that provision is set forth in this *Agreement.*

Group Delegation to Health Plan of Administrative Billing Functions

Group hereby delegates to Health Plan the following administrative billing functions:

- Billing and collecting Premiums under this *Agreement.*
- Terminating the memberships of Group's Members for nonpayment of Premiums.

Group retains all other responsibilities, such as meeting applicable contribution and participation requirements and distributing information about coverage to potential Subscribers before enrollment.

When an employee becomes eligible for retiree coverage through Group in Health Plan, Group will notify Health Plan of the enrollment and the effective date. Health Plan will then bill and collect Premium from the Subscriber.

Group will notify Health Plan when a Member's membership terminates, except for terminations that Health Plan initiates, for example termination for nonpayment of Premium or termination for cause in accord with Chapter 10, Section 5 ("We must end your membership in our plan in certain situations") of the EOC for Senior Advantage.

Health Plan will send Group a monthly report of membership status that includes the names of all Members who are currently enrolled and the memberships that Health Plan has terminated for nonpayment during the prior month.

No Waiver

Health Plan's failure to enforce any provision of this *Agreement* will not constitute a waiver of that or any other provision, or impair Health Plan's right thereafter to require Group's strict performance of any provision.

Notices

Notices must be sent to the addresses listed below, except that Health Plan or Group may change its address for notices by giving written notice to the other. Notices are deemed given when delivered in person, sent via email, or deposited in a U.S. Postal Service receptacle for the collection of U.S. mail.

Notices from Health Plan to Group will be sent to:

Group Contact	Tami Mahrt
Group Name	Multnomah County Employees
Group Address	Employee Benefits
Group Address	501 Se Hawthorne Blvd Ste 400
Group Address	Portland, OR 97214

Producer Contact	Timothy Cooper
Producer Name	Brown & Brown Of Or Llc Dba Brown
Producer Address	Po Box 743061
Producer Address	
Producer Address	Los Angeles, CA 90074-3061

Note: when Health Plan sends Group a new (or renewed) group agreement, Health Plan will enclose a summary that discusses the changes Health Plan has made to this *Agreement*. Groups that want information about changes before receiving the new group agreement may request advance information from Group's Health Plan account manager. Also, if Group designates in writing a third party such as a "Producer of Record," Health Plan may send the advance information to the third party rather than to Group (unless Group requests a copy also).

Notices from Group to Health Plan regarding billing and enrollment must be sent to:

Kaiser Foundation Health Plan of the Northwest
P.O. Box 23127
San Diego, CA 92193
Or emailed to: csc-den-roc-group@kp.org

Notices from Group to Health Plan regarding Premium payments must be sent to:

Kaiser Foundation Health Plan of the Northwest
PO Box 34178
Seattle, WA 98124

Notices from Group to Health Plan regarding termination of this *Agreement* must be sent to the Group's account manager at:

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah Street, Suite 100
Portland, OR 97232

Reporting Membership Changes and Retroactivity

Health Plan's billing statement to Group explains how to report membership changes. Group's Kaiser Permanente account manager can also provide Group with this information. Group must report membership changes (including sending Health Plan-approved membership forms) within the time limit for retroactive changes. Except for Senior Advantage membership terminations discussed below, the time limit for retroactive membership changes is the calendar month when Health Plan's San Diego Service Center receives Group's notification of the change plus the previous two months unless Health Plan agrees otherwise in writing.

Involuntary Kaiser Permanente Senior Advantage Membership Terminations

Group must give Health Plan's Denver Service Center 30 days prior written notice of Senior Advantage involuntary membership terminations. An involuntary Kaiser Permanente Senior Advantage membership termination is a termination that is not in response to a disenrollment notice issued by CMS to Health Plan or received by Health Plan directly from a Member (these events are usually in response to a Member's request for disenrollment to CMS because the Member has enrolled in another Medicare health plan or wants Original Medicare coverage or has lost Medicare eligibility). The membership termination date is the first of the month following 30 days after the date when Health Plan's Denver Service Center receives a Senior Advantage membership termination notice unless Group specifies a later termination date. For example, if Health Plan's Denver Service Center receives a termination notice on March 5 for a Senior Advantage Member, the earliest termination date is May 1 and Member is required to pay applicable Premiums for the months of March and April.

Voluntary Kaiser Permanente Senior Advantage Membership Terminations

If Health Plan's Denver Service Center receives a disenrollment notice from CMS or a membership termination from the Member, the Kaiser Permanente Senior Advantage membership termination date will be in accord with CMS requirements.

Social Security and Tax Identification Numbers

Within 60 days after Health Plan sends Group a written request, Group will send Health Plan a list of all Members covered under this *Agreement,* along with the following:

- The Member's Social Security number.
- The tax identification number of the employer of the Subscriber in the Member's Family.
- Any other information that Health Plan is required by law to collect.

GUIDE TO YOUR BENEFITS AND SERVICES

kp.org

Medical Benefits Chart: Senior Advantage with Part D

Multnomah County Employees
1569 - 452

For group benefits effective 01/01/2024 through 12/31/2024

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

Services that are covered for you	What you must pay when you get these services
Maximum out-of-pocket amount	**$600**
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain (physician-referred)† Covered services include: • Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: ♦ For the purpose of this benefit, chronic low back pain is defined as: o Lasting 12 weeks or longer. o Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.). o Not associated with surgery. o Not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be	**$10 per visit**

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • A master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • A current, full, active, and unrestricted license to practice acupuncture in a state, territory, or commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by regulations at 42 CFR §§ 410.26 and 410.27.	
Alternative care therapies (self-referred) Visit limits (if any) are on a calendar year basis**.**	
• Acupuncture services (up to 20 visits per calendar year)	**$15 per visit** (If covered, see the Acupuncture Services Rider in the **EOC** for additional information.)
• Chiropractic services (up to 20 visits per calendar year)	**$15 per visit**

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
	(If covered, see the Chiropractic Services Rider in the **EOC** for additional information.)
• Massage therapy (up to 12 visits per calendar year)	**$25 per visit** (If covered, see the Massage Therapy Rider in the **EOC** for additional information.)
• Naturopathic medicine	**$10 per visit** (If covered, see the Naturopathic Medicine Rider in the **EOC** for additional information.)
Ambulance services Covered ambulance services, whether for an emergency or †non-emergency situation, include fixed wing, rotary wing, and ground ambulance services to the nearest appropriate facility that can provide care if they 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. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. We also cover the services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) if you reasonably believe that you have an emergency medical condition and you reasonably believe that your condition requires the clinical support of ambulance transport services.	**$50** per one-way trip

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
Annual routine physical exams Routine physical exams are covered if the exam is medically appropriate preventive care in accord with generally accepted professional standards of practice.	There is no coinsurance, copayment, or deductible for this preventive care.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement For qualified 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 aged 40 and older.	There is no coinsurance, copayment, or deductible for covered screening mammograms.

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
• Clinical breast exams once every 24 months.	
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 cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**$10** per visit
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease 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.

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
Chiropractic services (physician-referred)† Covered services include: • We cover only manual manipulation of the spine to correct subluxation. ♦ These Medicare-covered services are provided by a network chiropractor. For the list of network chiropractors, please refer to the **Provider Directory**.	**$10 per visit**
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and you pay **$0.**

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
• Barium enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result.	
• Procedures performed during a screening colonoscopy (for example, removal of polyps). • Colonoscopies following a positive gFOBT or FIT test or a flexible sigmoidoscopy screening. **Note:** All other colonoscopies are subject to the applicable cost-sharing listed elsewhere in this chart.	**$0**
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.

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
Diabetes self-management training, 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 and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.	**$0**
• †For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 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.	**$0**
Diabetes self-management training is covered under certain conditions.	**$0**
Durable medical equipment (DME) and related supplies† (For a definition of durable medical equipment, see Chapter 12 as well as Chapter 3, Section 7, of this document.) 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	• **$0** for ultraviolet light therapy equipment for psoriasis treatment, CADD pumps, bone/spine stimulators, and ventilators, and enteral pumps/supplies • **$0** for all other DME **Oxygen equipment** Your cost sharing for Medicare oxygen equipment coverage is **20%,** every time you receive equipment. Your cost sharing will not change after being enrolled for 36 months.

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
you. The most recent list of suppliers is available on our website at **kp.org/directory.** We also cover the following DME not covered by Medicare when medically necessary: • Bed accessories when bed extension is required. • Iontophoresis device to treat hyperhidrosis when antiperspirants are contraindicated and the hyperhidrosis has created medical complications or is preventing daily living activities. • Resuscitation bag if tracheostomy patient has significant secretion management problems, needing lavage and suction technique aided by deep breathing via resuscitation bag.	
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. **You have worldwide emergency care coverage.**	**$50** 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 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.

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
Fitness benefit (the Silver&Fit® Healthy Aging and Exercise Program) The Silver&Fit program includes the following: • You can join a participating Silver&Fit fitness center and take advantage of the services that are included in the fitness center's standard membership (for example, use of fitness center equipment or instructor-led classes that do not require an additional fee). If you sign up for a Silver&Fit fitness center membership, the following applies: ♦ The fitness center provides facility and equipment orientation. ♦ Services offered by fitness centers vary by location. Any nonstandard fitness center service that typically requires an additional fee is not included in your standard fitness center membership through the Silver&Fit program (for example, court fees or personal trainer services). ♦ To join a participating Silver&Fit fitness center, register through **kp.org/SilverandFit** and select your location(s). You can then print or download your "Welcome Letter," which includes your Silver&Fit card with fitness ID number to provide to the selected fitness center. ♦ Once you join, you can switch to another participating Silver&Fit fitness center once a month and your change will be effective the first of the following month (you may need to complete a new membership agreement at the fitness center).	**$0**

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
• If you would like to work out at home, you can select one Home Fitness Kit per calendar year. There are many Home Fitness Kits to choose from, including Wearable Fitness Tracker, Pilates, Strength, Swim, Walking/Trekking and Yoga Kit options. Kits are subject to change and once selected cannot be exchanged. • To pick your kit, please visit **kp.org/SilverandFit** or call Silver&Fit customer service. • Access to Silver&Fit online services at **kp.org/SilverandFit** that provide on-demand workout videos, Workout Plans, the Well-Being Club, a newsletter, and other helpful features. The Well-Being Club enhanced feature of the Silver&Fit website allows members the opportunity to view customized resources as well as attend live virtual classes and events For more information about the Silver&Fit program and the list of participating fitness centers and home kits, visit **kp.org/SilverandFit** or call Silver&Fit customer service at **1-877-750-2746** (TTY **711**), Monday through Friday, 5 a.m. to 6 p.m. (PST). The Silver&Fit program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit is a federally registered trademark of ASH and used with permission herein. Fitness center participation may vary by location and is subject to change.	
Health and wellness education programs Health and wellness programs include weight management, quitting tobacco, diabetes management, life care planning, prediabetes, and more. Registered dietitians, health coaches,	**$0**

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
certified diabetes educators, and other health professionals facilitate our classes. We offer in-person, online, and phone options to fit your learning style. Please see our health and wellness classes and resources catalog at **kp.org/healthylivingcatalog/nw**. Contact Member Services for more details or to request a copy of our catalog.	
Hearing services • Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. • Routine hearing exams.	**$20** per visit
• *Hearing aids, including evaluation and fitting.	**Balance after $4,000 allowance is applied for each hearing aid per ear every 48 months** (If covered, see the Hearing Aid Rider in the **EOC** for additional information.)
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 after each exposure. • 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-based palliative care† Services not covered by Medicare in the home are provided in the form of palliative care to diminish symptoms of terminally ill members with a life expectancy of 7–12 months. Services include non-Medicare-covered palliative nursing and	**$0**

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
social work services in the home.	
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.	**$0** **Note:** There is no cost-sharing for home health care services and items provided in accord with Medicare guidelines. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply if the item is covered under a different benefit; for example, durable medical equipment not provided by a home health agency.
Home infusion therapy† Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care. • Patient training and education not otherwise covered under the durable medical equipment benefit.	**$0** for professional services, training, and monitoring. The components (such as, Medicare Part B drugs, DME, and medical supplies) needed to perform home infusion may be subject to the applicable cost-sharing listed elsewhere in this Medical Benefits Chart depending on the item.

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
• Remote monitoring. • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	
We cover home infusion supplies and drugs if all of the following are true: • Your prescription drug is on our Medicare Part D formulary. • We approved your prescription drug for home infusion therapy. • Your prescription is written by a network provider and filled at a network home-infusion pharmacy.	**$0** **Note:** If a covered home infusion supply or drug is not filled by a network home-infusion pharmacy, the supply or drug may be subject to the applicable cost-sharing listed elsewhere in this document depending on the service.
Home medical care not covered by Medicare (Kaiser Permanente at Home)† **This benefit is unavailable to members in Lane County.** We cover medical care in your home that is not otherwise covered by Medicare in certain situations to provide you with an alternative to receiving acute care in a hospital. Services in the home must be: • Prescribed by a network hospitalist who has determined that based on your health status, treatment plan, and home setting that you can be treated safely and effectively in the home. • Elected by you because you prefer to receive the care described in your treatment plan in your home. Services are provided or arranged by our plan and Medically Home. Medically Home is our network provider and will provide the following services and items in your home in accord with your treatment plan for as long as they are prescribed by	**$0**

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
a network hospitalist: • Home visits by RNs, physical therapists, occupational therapists, speech therapists, respiratory therapists, nutritionist, home health aides, and other healthcare professionals in accord with the home care treatment plan and the provider's scope of practice and license. • Communication devices to allow you to contact Medically Home's command center 24 hours a day, 7 days a week. This includes needed communication technology to support reliable communication, and a PERS alert device to contact Medically Home's command center if you are unable to get to a phone. • Equipment necessary to ensure that you are monitored appropriately in your home: Blood pressure cuff/monitor, pulse oximeter, scale, and thermometer. • Laboratory tests, mobile imaging (X-rays, ultrasounds), and EKGs. • The following safety items: Shower stools, raised toilet seats, grabbers, long handle shoehorn, and sock aid. • Meals while you are receiving acute care in the home.	
In addition, for Medicare-covered services and items listed below, the cost-sharing indicated elsewhere in this Medical Benefits Chart does not apply when the services and items are prescribed as part of your Kaiser Permanente at Home treatment plan: • Durable medical equipment. • Medical supplies. • Ambulance transportation to and from network facilities when ambulance transport is medically necessary.	**$0**

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
• Physician assistant and nurse practitioner house calls. • The following services at a network facility if the services are part of your home treatment plan: ♦ Network Emergency Department visits associated with this program. The cost-sharing indicated elsewhere in this Medical Benefits Chart will apply to all other services and items that aren't part of your Kaiser Permanente at Home treatment plan (for example, DME not specified in your Kaiser Permanente at Home treatment plan) or are part of your home treatment plan, but are not provided in your home except as listed above. **Note:** For prescription drug cost-sharing information, please refer to the Medicare Part B prescription drug section in this chart and Chapter 6 for Medicare Part D prescription drugs.	
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in your plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief. • Short-term respite care. • Home care.	When you 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 maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan, you must continue to pay plan premiums. ***For hospice services and for 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 your hospice provider 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. You will be billed Original Medicare cost-sharing. **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 and follow plan rules (such as if there is a requirement to obtain prior authorization): • If you obtain the covered services from a network provider and follow plan rules for obtaining service, 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).	

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
For services that are covered by our plan but are not covered by Medicare Part A or B: We will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. **For drugs that may be covered by our plan's Part D benefit:** If these drugs are unrelated to your terminal hospice condition, you pay cost-sharing. If they are related to your terminal hospice condition, then you pay Original Medicare cost-sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4, "What if you're in Medicare-certified hospice." **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 for a terminally ill person who hasn't elected the hospice benefit.	**$0**
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. • COVID-19 vaccine. • Other vaccines if you are at risk and they meet Medicare Part B coverage rules. We also cover some vaccines under our Part D	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
prescription drug benefit.	
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. There is no limit to the number of medically necessary hospital days or services that are generally and customarily provided by acute care general hospitals. Covered services include, but 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.	**$50 per day up to $250 per admission** Thereafter you pay $0 for the remainder of your covered hospital stay. You do not pay the copayment listed above for the day you are discharged unless you are admitted and discharged on the same day. †If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. **Note:** If you are admitted to the hospital in 2023 and are not discharged until sometime in 2024, the 2023 cost-sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility.

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Services that are covered for you	What you must pay when you get these services
• Under certain conditions, the following types of transplants are covered: Corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will 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, in accord with our travel and lodging guidelines, which are available from Member Services. • Blood—including storage and administration. • Physician services.	
Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you 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/2021-10/11435-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.	

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Services that are covered for you	What you must pay when you get these services
Inpatient services in a psychiatric hospital† Covered services include mental health care services that require a hospital stay. • We cover up to 190 days per lifetime for inpatient stays in a Medicare-certified psychiatric hospital. The number of covered lifetime hospitalization days is reduced by the number of inpatient days for mental health treatment previously covered by Medicare in a psychiatric hospital. • The 190-day limit does not apply to mental health stays in a psychiatric unit of a general hospital.	**$50 per day up to $250 per admission** Cost-sharing is charged for each inpatient stay. You do not pay the copayment listed above for the day you are discharged unless you are admitted and discharged on the same day. **Note:** If you are admitted to the hospital in 2023 and are not discharged until sometime in 2024, the 2023 cost-sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility.
Inpatient stay: Covered services 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. • Diagnostic tests (like lab tests). • X-rays, radium, and isotope therapy, including technician materials and services. • Surgical dressings. • Splints, casts, and other devices used to reduce fractures and dislocations.	If your inpatient or SNF stay is no longer covered, we will continue to cover Medicare Part B services at the applicable cost-sharing listed elsewhere in this Medical Benefits Chart when provided by network providers.

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Services that are covered for you	What you must pay when you get these services
• 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. • Physical therapy, speech therapy, and occupational therapy.	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 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 Advantage 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 order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change	There is no coinsurance, copayment, or deductible for the MDPP benefit.

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Services that are covered for you	What you must pay when you get these services
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.	
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: • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump). • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan. • 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.	Your applicable Part D prescription drug copayment or coinsurance
• 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.	**$0**
• 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.	**$0**

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Services that are covered for you	What you must pay when you get these services
• Antigens. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa).	**$0**
Note: • We also cover some vaccines under our Part B prescription drug benefit.	
***Medicare Part D prescription drugs†** Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6 and listed here.	**$10 generic/$20 brand, for up to a 30-day supply, per prescription. When you get your drugs from our mail-order pharmacy, you may get up to a 31-90 day supply for two copayments. Insulin is subject to the applicable drug tier cost-sharing up to $35 for each 30-day supply. After you have paid $8,000 out-of-pocket for Part D covered drugs in a calendar year, you pay nothing for the remainder of the year.**
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services† Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program	**$0** for clinically administered Medicare Part B drugs when provided by an Opioid Treatment Program

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Services that are covered for you	What you must pay when you get these services
(OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable).	
• Substance use counseling. • Individual and group therapy. • Toxicology testing. • Intake activities. • Periodic assessments.	**$20** per visit
Outpatient diagnostic tests and therapeutic services and supplies† Covered services include, but are not limited to: • Laboratory tests.	**$0 per department visit**
♦ INR lab tests for persons with liver disease or certain bleeding disorders ♦ A1c lab tests for persons with diabetes ♦ LDL lab tests for person with heart disease	**$0**
• Blood—including storage and administration.	**$0**
• X-rays. • Electrocardiograms (EKGs), holter monitoring, and electroencephalograms (EEGs). • Ultrasounds. • Sleep studies.	**$0 per department visit**
• Radiation (radium and isotope) therapy, including technician materials and supplies.	**$10** per visit
• Surgical supplies, such as dressings.	**$0** for surgical supplies or casts

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Services that are covered for you	What you must pay when you get these services
• Splints, casts, and other devices used to reduce fractures and dislocations.	**$0** for take-home dressings and supplies, splints, and other devices to reduce fractures and dislocations
• Other outpatient diagnostic tests: ♦ Magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET).	**$0 per department visit**
♦ Any diagnostic test or special procedure that is provided in an outpatient department of a hospital or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.	**$25** per visit
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	**$50** per stay when admitted directly to the hospital for observation as an outpatient **Note:** There's no additional charge for outpatient observation stays when transferred for observation from an Emergency Department or following outpatient surgery.

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Services that are covered for you	What you must pay when you get these services
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/2021-10/11435-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 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** **$50** per visit **Outpatient surgery** **$25** per visit Refer to the "Outpatient hospital observation" section of this Medical Benefits Chart for the cost-sharing applicable to observation services.
• Laboratory and diagnostic tests billed by the hospital. • X-rays and other radiology services billed by the hospital.	**Lab tests** • **$0 per department visit** **X-rays, ultrasounds, EKG, EEG, sleep studies, and holter monitorin** • **$0 per department visit** **Radiation therapy** • **$10** per visit **MRI, CT, and PET** • **$0 per department visit**
• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it.	**$10** per day

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Services that are covered for you	What you must pay when you get these services
• Medical supplies such as splints and casts.	**$0** for surgical supplies or casts **$0** for splints or take home dressings and supplies
• Certain drugs and biologicals that you can't give yourself.	**$0**
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/2021-10/11435-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, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	• **$10** per individual therapy visit • **$5** per group therapy visit
Outpatient rehabilitation services† Covered services include: Physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient	**$10** per visit (or per day in a CORF)

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Services that are covered for you	What you must pay when you get these services
Rehabilitation Facilities (CORFs).	
Outpatient substance abuse services† Covered services include: • Intensive outpatient treatment program.	• **$10** per individual therapy visit • **$5** per group therapy visit
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers† **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.	**$25** per visit
Outside service area benefit If you travel outside our service area, but inside the United States or its territories, we cover preventive, routine, follow-up, or continuing care office visits obtained from out-of-network Medicare providers not to exceed **$1,000** in covered Plan Charges per calendar year. We will pay up to 80% of the Medicare allowable charge, if the provider accepts assignment. Otherwise, we will pay 80% of the Medicare limiting charge, if the provider does not accept assignment.	**20%** of the Medicare allowable or limiting charges, and any amounts that exceed **$1,000** in Plan Charges per calendar year
Partial hospitalization services and	**$10** per day

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Services that are covered for you	What you must pay when you get these services
intensive outpatient services† Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that 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. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	
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.	**Note:** Cost-sharing is charged based on the medical department where the service is provided, not the type of provider. In addition, multiple copayments may apply, depending on services provided and whether a consultation occurs. **Primary care office visits** • **$10** per visit **Specialist office visits** • **$20** per visit

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Services that are covered for you	What you must pay when you get these services
• †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).	**Outpatient hospital department or surgical center** You pay the following per visit when it is provided in an outpatient or ambulatory surgery center, or in a hospital operating room, or in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort: • **$25**
• Chemotherapy visits.	**$10** per visit
• †Ultraviolet light treatments.	**$5** per visit
• †Visits for injections administered in outpatient settings.	**$0** per injection
• Certain telehealth services, including: Primary and specialty care, which includes inpatient hospital acute, inpatient hospital psychiatric, cardiac rehabilitation services, emergency services, urgently needed services, home health services, occupational therapy, mental health, podiatry services, psychiatric services, physical therapy and speech-language pathology services, outpatient substance abuse, dialysis services, kidney disease education services, diabetes self-management training, preparation for surgery or a hospital stay, and follow up visits after a hospital stay, surgery, or Emergency Department visit. Services will only be provided by telehealth when deemed clinically appropriate by the network provider rendering the service.	**$0**

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Services that are covered for you	What you must pay when you get these services
♦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. We offer the following means of telehealth: o Interactive video visits for professional services when care can be provided in this format as determined by a network provider. o Scheduled telephone appointment visits for professional services when care can be provided in this format as determined by a network provider. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home. • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location. • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location. • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ♦ You have an in-person visit within 6 months prior to your first telehealth visit. ♦ You have an in-person visit every 12 months while receiving these telehealth services. ♦ Exceptions can be made to the above for certain circumstances. • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers.	

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Services that are covered for you	What you must pay when you get these services
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5 to 10 minutes if: ♦ You're not a new patient and, ♦ The check-in isn't related to an office visit in the past 7 days and, ♦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment. • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: ♦ You're not a new patient and, ♦ The evaluation isn't related to an office visit in the past 7 days and, ♦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment. • Consultation your doctor has with other doctors by phone, internet, or electronic health record.	
Podiatry services† Covered services include: • 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.	**Specialist office visits** • **$20** per visit **Outpatient hospital department or surgical center** You pay the following per visit when it is provided in an outpatient or ambulatory surgery center, or in a hospital operating room, or in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort: • **$25**
Prostate cancer screening exams For men aged 50 and older, covered services	There is no coinsurance, copayment, or deductible for an annual digital rectal exam or PSA test.

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Services that are covered for you	What you must pay when you get these services
include the following—once every 12 months: • Digital rectal exam. • Prostate Specific Antigen (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 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). Includes wigs following chemotherapy or radiation therapy (up to one synthetic wig per year).	**$0** for external prosthetic or orthotic devices and supplies (including wound care supplies) **$0** for surgically implanted internal devices and enteral and parenteral nutrition therapy
Pulmonary rehabilitation services† Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**$10** per visit
Residential substance use disorder and mental health treatment† We cover the following services when the services are provided in a licensed residential treatment facility that provides 24-hour individualized substance use disorder or mental health treatment, the services are generally and customarily provided by a substance use disorder or mental health residential treatment program in a licensed residential treatment facility, and the services are above the level of custodial care:	**$25 per day up to $125 per admission** Cost-sharing is charged per admission to a residential treatment program.

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Services that are covered for you	What you must pay when you get these services
• Individual and group counseling. • Medical services. • Medication monitoring. • Room and board. • Drugs prescribed by a network provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel. • Discharge planning. There is no limit to the number of medically necessary days in our residential treatment program to treat mental health conditions and substance abuse when prescribed by a network provider.	
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 50–77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or	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
have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling 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 members 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.

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Services that are covered for you	What you must pay when you get these services
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.	**$0**
• †Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible).	**$0**
• †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).	**$0**
• †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, **Medicare Part B prescription drugs**.	
Skilled nursing facility (SNF) care† (For a definition of skilled nursing facility care, see Chapter 12 of this document. Skilled nursing facilities are sometimes called SNFs.)	**$0** **Note:** If a benefit period begins in 2023 for you and does not end until sometime in 24, the 2023 cost-sharing will continue until the benefit period ends.

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Services that are covered for you	What you must pay when you get these services
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. • Medical and surgical supplies ordinarily provided by SNFs. • Laboratory tests ordinarily provided by SNFs. • X-rays and other radiology services ordinarily provided by SNFs. • Use of appliances such as wheelchairs ordinarily provided by SNFs. • Physician/practitioner services. Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse or domestic partner is living at the time you leave the hospital.	

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Services that are covered for you	What you must pay when you get these services
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: • 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.	**$10** per visit

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
• 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 non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. Examples of urgently needed services that the plan must cover out-of-network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. • **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).	**Office visits** **$30** per visit **Emergency Department visits** **$50** per visit

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
• **Outside our service area:** You have worldwide urgent care coverage when you travel if you need medical attention right away for an unforeseen illness or injury and you reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our service area. **See Chapter 3, Section 3, for more inofrmation.**	
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.	**$20** per visit
• Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. However, our plan does cover the following exams: ♦ Routine eye exams (eye refraction exams) to determine the need for vision correction and to provide a prescription for eyeglass lenses. • Visual field tests.	**$10** per visit
• 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 Americans who are age 50 and older, and Hispanic Americans who are 65 or older. • For people with diabetes, screening for and monitoring of diabetic retinopathy.	**$0**

†Your provider must obtain prior authorization from our plan.
*Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
• One pair of eyeglasses or one conventional contact lens or up to a six-month supply of disposable lenses (including fitting and dispensing) after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you can 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.	$0 for eyewear in accord with Medicare guidelines *Note: If the eyewear you purchase costs more than what Medicare covers, you pay the difference.
• *Prescription eyewear (eyeglass lenses, eyeglass frames, and contact lenses).	**Balance after $150 allowance to use every 24 months** (If covered, see the Prescription Eyewear Rider in the **EOC** for additional information.)
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 6) and Chapter 11 (Section 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 maximum out-of-pocket amount.

Evidence of Coverage

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

This document gives you the details about your Medicare health care and prescription drug coverage from January 1 to December 31, 2024. This is an important legal document. Please keep it in a safe place.

For questions about this document, please contact Member Services at **1-877-221-8221** for additional information. (TTY users should call **711**.) Hours are 8 a.m. to 8 p.m., 7 days a week. This call is free.

This plan, Kaiser Permanente Senior Advantage, is offered by Kaiser Foundation Health Plan of the Northwest (Health Plan). When this **Evidence of Coverage** says "we," "us," or "our," it means Health Plan. When it says "plan" or "our plan," it means Kaiser Permanente Senior Advantage (Senior Advantage).

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

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2025. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

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

- Your plan premium and cost-sharing;
- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

KAISER PERMANENTE®

2024 Evidence of Coverage

Table of Contents

Chapter 1 – Getting started as a member

Section 1 – Introduction

Section 1.1 – You are enrolled in Senior Advantage, which is a Medicare HMO Plan

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

We are required to cover all Part A and Part B services. However, cost-sharing and provider access in this plan differ from Original Medicare.

Senior Advantage is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) 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 **www.irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information.

Section 1.2 – What is the Evidence of Coverage document about?

This **Evidence of Coverage (EOC)** document tells you how to get your medical care and prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of our plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words **coverage** and **covered services** refer to the medical care and services and the prescription drugs 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 document.

If you are confused, concerned, or just have a question, please contact Member Services.

Section 1.3 – Term of the Evidence of Coverage

This **Evidence of Coverage** explains what our plan covers, in addition to your enrollment form, our **2024 Comprehensive Formulary,** 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.**

If your group renews on January 1, the **Evidence of Coverage** is in effect for the months in which you are enrolled in Senior Advantage between January 1, 2024, and December 31, 2024, unless amended.

If your group's **Agreement** renews at a later date in 2024, the term of this **Evidence of Coverage** is during that contract period, unless amended.

Your group can tell you the term of this **Evidence of Coverage** and whether this **Evidence of Coverage** is still in effect, and give you a current one if this **Evidence of Coverage** has been amended.

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue each year to get Medicare coverage as a member of our plan only as long as your group continues to offer this plan, 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 Senior Advantage eligibility requirements

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

- You have both Medicare Part A and Medicare Part B.
- You live in our geographic service area (Section 2.4 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- You are a United States citizen or are lawfully present in the United States.

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

Section 2.2 – Group eligibility requirements

In addition to the Senior Advantage eligibility requirements in this section, you must meet the following requirements to be eligible to enroll and to remain enrolled under your group's plan:

- You must meet your group's eligibility requirements that we have approved. (Your group is required to inform subscribers of its eligibility requirements.)
- You must meet the subscriber and dependent eligibility requirements described below unless your group has different eligibility requirements that we have approved.

You may be eligible to enroll as a subscriber under this Evidence of Coverage if you are:

- An employee of your group, or
- Otherwise entitled to coverage through your group under a trust agreement, retirement benefit program, rules of a professional, trade, or bona fide association, or employment contract (unless the Internal Revenue Service considers you self-employed).

If you are a subscriber enrolled under this **Evidence of Coverage** or a subscriber enrolled in a non-Medicare plan offered by your group, the following persons may be eligible to enroll as your dependents under this **Evidence of Coverage** if they meet all the other requirements described under this Section 2:

- Your spouse.
- A person who is under the dependent limiting age specified by your group and who is any of the following (check with your group to determine the age limit for dependents):
  - Your or your spouse's child.
  - A child adopted by you or your spouse, or for whom you or your spouse have assumed a legal obligation in anticipation of adoption.
  - Any other person for whom you or your spouse is a court-appointed guardian.
- A person of any age who is chiefly dependent upon you or your spouse for support and maintenance if the person is incapable of self-sustaining employment by reason of developmental disability or physical handicap which occurred prior to their reaching the dependent limiting age specified by your group, if the person is any of the following:
  - Your or your spouse's child.
  - A child adopted by you or your spouse, or for whom you or your spouse have assumed a legal obligation for total or partial support in anticipation of adoption.
  - Any other person for whom you or your spouse is a court-appointed guardian and was a court-appointed guardian prior to the person's reaching the dependent limiting age specified by your group.

We may request proof of incapacity and dependency annually.

Note: Children born to an eligible dependent other than your spouse are not eligible for coverage beyond the first 31 days of life, including the date of birth, unless:

- You or your spouse adopts them or assumes a legal obligation in anticipation of adoption, or
- They are primarily supported by you or your spouse and you or your spouse is their court-appointed guardian.

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

Section 2.3 – When you can enroll and when coverage begins

Your group is required to inform you when you are eligible to enroll and your effective date of coverage under this **Evidence of Coverage**. If you are eligible to enroll as described in this Section 2, enrollment is permitted and membership begins at the beginning (12:00 a.m.) of the effective date of coverage, except that:

- Your group may have additional requirements that we have approved, which allow enrollment in other situations.

- The effective date of your Senior Advantage coverage under this **Evidence of Coverage** must be confirmed by the Centers for Medicare & Medicaid Services (CMS), as described in this Section 2.3.

If you are eligible to be a dependent under this **Evidence of Coverage** but the subscriber in your family is enrolled under a non-Medicare plan offered by your group, the subscriber must follow the rules applicable to subscribers who are enrolling dependents in this Section 2.3.

New subscribers

When your group informs you that you are eligible to enroll as a subscriber, you may enroll yourself and any eligible dependents by submitting the applicable Health Plan-approved enrollment application or Senior Advantage Election Form for each person, to your group within 31 days.

After we receive your completed Senior Advantage Election Form, we will submit your enrollment request to CMS for confirmation and send you a notice indicating the proposed effective date of your Senior Advantage coverage under this **Evidence of Coverage**.

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

Adding new dependents to an existing account

To enroll a dependent who first becomes eligible to enroll after you became a subscriber (such as a new spouse, a newborn child, or a newly adopted child), you must submit the applicable Health Plan–approved change of enrollment form or a Senior Advantage Election Form to your group within 31 days after the dependent first becomes eligible. The effective date of coverage for newly acquired dependents is determined by your group, subject to confirmation by CMS.

Group open enrollment

Your group will let you know when their open enrollment period begins and ends. You may enroll as a subscriber along with any eligible dependents, and existing subscribers may add eligible dependents not previously enrolled, by submitting a Health Plan-approved enrollment application and/or a Senior Advantage Election Form for each person to your group. Your group will let you know the effective date of coverage, subject to confirmation by CMS.

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless you experience a qualifying event as defined in applicable federal law. Examples of qualifying events include, but are not limited to:

- Gaining a dependent through marriage, birth, adoption or placement for adoption.
- Loss of a dependent through divorce or legal separation, or if the enrollee or his or her dependent dies.

Note: If you are enrolling as a subscriber along with at least one eligible dependent, only one of you must meet one of the requirements for a qualifying event.

You must notify your group within 30 days of a qualifying event, 60 days if you are requesting enrollment due to a change in eligibility for Medicaid or Child Health Insurance Program (CHIP) coverage. Your group will determine if you are eligible to select or change coverage. Contact your group for further instructions on how to enroll.

Note: If you previously declined coverage, your group may have required you to provide a written statement indicating whether the coverage was being declined due to other health coverage. If this statement is not provided, or if coverage was not declined due to other health coverage, you may not be eligible for special enrollment due to loss of other health coverage. Contact your group for further information.

Section 2.4 – Here is our plan service area for Senior Advantage

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 counties in Oregon: **Clackamas, Columbia, Hood River, Lane, Marion, Multnomah, Polk, Washington**, and **Yamhill.** Also, our service area includes these parts of counties in Oregon, **in the following ZIP codes only:**

- **Benton:** 97321, 97330, 97331, 97333, 97339, 97370.
- **Linn:** 97321, 97322, 97335, 97355, 97358, 97360, 97374, 97383, 97389.

Our service area includes **Clark, Cowlitz**, and **Skamania** counties in **Washington.** Also, our service area includes parts of **Wahkiakum County** in **Washington, in the following ZIP codes only:** 98612, 98647.

If you plan to move out of the service area, you cannot remain a member of this plan.

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 2.5 – 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 – Important membership materials you will receive

Section 3.1 – Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. 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:

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

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Section 3.2 – Provider Directory

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

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

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

The most recent list of providers and suppliers is available on our website at **kp.org/directory**. If you don't have your copy of the **Provider Directory**, you can request a copy (electronically or in hardcopy form) from Member Services. Requests for hard copy provider directories will be mailed to you within three business days.

Section 3.3 – Pharmacy Directory

The **Pharmacy Directory** lists our network pharmacies. Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the **Pharmacy Directory** to find the network pharmacy you want to use. See Chapter 5, Section 2.5, for information on when you can use pharmacies that are not in the plan's network.

If you don't have the **Pharmacy Directory**, you can get a copy from Member Services. You can also find this information on our website at **kp.org/directory**.

Section 3.4 – Our plan's list of covered drugs (formulary)

Our plan has a **2024 Comprehensive Formulary**. We call it the "Drug List" for short. It tells you which Part D prescription drugs are covered under the Part D benefit included in our plan. The drugs on this list are selected by our plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved our plan’s "Drug List."

The "Drug List" also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of our "Drug List." To get the most complete and current information about which drugs are covered, you can visit our website **(kp.org/seniorrx)** or call Member Services.

Section 4 – Costs

Your costs may include the following:

- Plan premium (Section 4.1).
- Monthly Medicare Part B premium (Section 4.2).
- Part D late enrollment penalty (Section 4.3).
- Income Related Monthly Adjusted Amount (Section 4.4).

Section 4.1 – Plan premium

Your coverage is provided through a contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your plan premium.

Section 4.2 – Monthly Medicare Part B premium

Many members are required to pay other Medicare premiums

You must continue paying your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A, which affects members who aren't eligible for premium-free Part A.

Section 4.3 – Part D late enrollment penalty

Some members are required to pay a Part D late enrollment penalty. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage. The Part D late enrollment penalty will be applied to the overall premium your group pays us. Your group will inform you if you are required to reimburse the Part D late enrollment penalty amount to the group.

You will not have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information because you may need it if you join a Medicare drug plan later.
  - **Note:** Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
  - **Note:** The following are not creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2024, this average premium amount is $34.70.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $34.70, which equals $4.85. This rounds to $4.90. This amount would be added to the monthly premium for someone with a Part D late enrollment penalty.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year** because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

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

Section 4.4 – Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from two years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit **https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.**

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **If you do not pay the extra amount, you will be disenrolled from the plan and lose prescription drug coverage.**

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

Section 5 – Keeping your plan membership record up-to-date

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, pharmacists, and other providers in our network need to have correct information about you. **These network providers use your membership record to know what services and drugs 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 or domestic partner'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. (**Note**: You are not required to tell your plan about the clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, please let us know by calling Member Service