KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern California Region

A nonprofit corporation

Kaiser Permanente Deductible HMO Plan
Evidence of Coverage for
CITI

Group ID: 8777 Contract: 1 Version: 97 *EOC* Number: 1

January 1, 2013, through December 31, 2013

Member Service Contact Center
24 hours a day, seven days a week
(except closed holidays, and closed after 5 p.m. the day after Thanksgiving, after 5 p.m. on Christmas Eve, and after 5 p.m. on New Year's Eve)
1-800-464-4000 toll free
1-800-777-1370 (toll free TTY for the hearing/speech impaired)
kp.org

Help in your language
Interpreters are available 24 hours a day, seven days a week, at no cost to you. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may be able to get materials written in your language. For more information, call our Member Service Contact Center at 1-800-464-4000 or 1-800-777-1370 (TTY) 24 hours a day, seven days a week (except holidays, and after 5 p.m. the day after Thanksgiving, Christmas Eve, and New Year's Eve).

Ayuda en su propio idioma
Tenemos disponibles intérpretes 24 horas al día, 7 días a la semana, sin ningún costo para usted. También podemos ofrecerle a usted, sus familiares y sus amigos cualquier tipo de ayuda que necesiten para tener acceso a nuestras instalaciones y servicios. Además, usted puede obtener materiales escritos en su idioma. Para más información, llame a nuestro Centro de Llamadas de Servicios a los Miembros al 1-800-788-0616 ó 1-800-777-1370 (TTY) los días de semana de 7 a.m. a 7 p.m., y los fines de semana de 7 a.m. a 3 p.m.

語言翻譯協助
提供每週七天，每天廿四小時翻譯。我們也向會員及其親友提供利用我處設施及服務所需之任何協助。此外會員還可索取以其母語編寫的資料。若需更多資訊，請於週一至週五上午七時至下午七時及週末上午七時至下午三時致電會員服務電話中心，電話號碼爲 1-800-757-7585 或 1-800-777-1370（聽障專線）。

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Benefit Highlights

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services, plus all your Deductible payments, add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$3,000 per calendar year
For any one Member in a Family of two or more Members	$3,000 per calendar year
For an entire Family of two or more Members	$6,000 per calendar year

Deductible for Certain Services	
For Services subject to the Deductible, you must pay Charges for Services you receive in a calendar year until you reach one of the following Deductible amounts:	
For self-only enrollment (a Family of one Member)	$500 per calendar year
For any one Member in a Family of two or more Members	$500 per calendar year
For an entire Family of two or more Members	$1,000 per calendar year

Lifetime Maximum	None

Professional Services (Plan Provider office visits)	You Pay
Most primary and specialty care consultations, exams, and treatment	10% Coinsurance after Deductible
Routine physical maintenance exams, including well-woman exams	No charge (Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Deductible doesn't apply)
Family planning counseling and consultations	No charge (Deductible doesn't apply)
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge (Deductible doesn't apply)
Eye exams for refraction	No charge (Deductible doesn't apply)
Hearing exams	No charge (Deductible doesn't apply)
Urgent care consultations, exams, and treatment	10% Coinsurance after Deductible
Physical, occupational, and speech therapy	10% Coinsurance after Deductible

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	10% Coinsurance after Deductible
Allergy injections (including allergy serum)	10% Coinsurance after Deductible
Most immunizations (including the vaccine)	No charge (Deductible doesn't apply)
Most X-rays and laboratory tests	10% Coinsurance after Deductible
Preventive X-rays, screenings, and laboratory tests as described in the "Benefits and Cost Sharing" section	No charge (Deductible doesn't apply)
Health education:	
Covered individual health education counseling	No charge (Deductible doesn't apply)
Covered health education programs	No charge (Deductible doesn't apply)

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	10% Coinsurance after Deductible

Emergency Health Coverage	You Pay
Emergency Department visits	$100 per visit (Deductible doesn't apply)
Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).	

Ambulance Services	You Pay
Ambulance Services	10% Coinsurance after Deductible

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply (Deductible doesn't apply)
Most generic refills through our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply (Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	$20 for up to a 30-day supply, $40 for a 31- to 60-day supply, or $60 for a 61- to 100-day supply (Deductible doesn't apply)
Most brand-name refills through our mail-order service	$20 for up to a 30-day supply or $40 for a 31- to 100-day supply (Deductible doesn't apply)

Durable Medical Equipment	You Pay
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	10% Coinsurance (Deductible doesn't apply)

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	10% Coinsurance after Deductible
Individual outpatient mental health evaluation and treatment	10% Coinsurance after Deductible
Group outpatient mental health treatment	10% Coinsurance after Deductible

Chemical Dependency Services	You Pay
Inpatient detoxification	10% Coinsurance after Deductible
Individual outpatient chemical dependency evaluation and treatment	10% Coinsurance after Deductible
Group outpatient chemical dependency treatment	10% Coinsurance after Deductible

Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	10% Coinsurance (Deductible doesn't apply)

Other	You Pay
Skilled Nursing Facility care (up to 100 days per benefit period)	10% Coinsurance after Deductible
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge (Deductible doesn't apply)
All Services related to covered infertility treatment	50% Coinsurance after Deductible
Hospice care	10% Coinsurance (Deductible doesn't apply)

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

Introduction

This *Evidence of Coverage* describes the health care coverage of "Kaiser Permanente Deductible HMO Plan" provided under the *Group Agreement (Agreement)* between Health Plan (Kaiser Foundation Health Plan, Inc.) and your Group (the entity with which Health Plan has entered into the *Agreement*). For benefits provided under any other Health Plan program, refer to that plan's evidence of coverage.

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

Please read the following information so that you will know from whom or what group of providers you may get health care. It is important to familiarize yourself with your coverage by reading this *Evidence of Coverage* completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

Term of this *Evidence of Coverage*

This *Evidence of Coverage* is for the period January 1, 2013, through December 31, 2013, unless amended. Your Group can tell you whether this *Evidence of Coverage* is still in effect and give you a current one if this *Evidence of Coverage* has expired or been amended.

About Kaiser Permanente

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

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

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Cost Sharing" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Hospice care as described under "Hospice Care" in the "Benefits and Cost Sharing" section

Definitions

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

Charges: "Charges" means the following:

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

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service as described in the "Benefits and Cost Sharing" section.

Copayment: A specific dollar amount that you must pay when you receive a covered Service as described in the "Benefits and Cost Sharing" section. Note: The dollar amount of the Copayment can be $0 (no charge).

Cost Sharing: The amount you are required to pay for a covered Service, for example: the Deductible, Copayment, or Coinsurance.

Deductible: The amount you must pay in a calendar year for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that calendar year. Please refer to the "Benefits and Cost Sharing" section for the Services that are subject to the Deductible(s) and the Deductible amount(s).

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

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable person would have believed that the absence of immediate medical attention would result in any of the following:

- Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

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

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

Emergency Services: All of the following with respect to an Emergency Medical Condition:

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

***Evidence of Coverage (EOC)*:** This *Evidence of Coverage* document, which describes the health care coverage of "Kaiser Permanente Deductible HMO Plan" under Health Plan's *Agreement* with your Group.

Family: A Subscriber and all of his or her Dependents.

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

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

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

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

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

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). In this *Evidence of Coverage*, Members who are "eligible for" Medicare Part A or B are those who would qualify for Medicare Part A or B coverage if they applied for it. Members who "have" Medicare Part A or B are those who have been granted Medicare Part A or B coverage.

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

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

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

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

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of

an existing condition (including pregnancy) if all of the following are true:

- You are temporarily outside our Service Area
- A reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to our Service Area

Plan Facility: Any facility listed in the "Plan Facilities" section or in a Kaiser Permanente guidebook *(Your Guidebook)* for our Service Area, except that Plan Facilities are subject to change at any time without notice. For the current locations of Plan Facilities, please call our Member Service Contact Center.

Plan Hospital: Any hospital listed in the "Plan Facilities" section or in a Kaiser Permanente guidebook *(Your Guidebook)* for our Service Area, except that Plan Hospitals are subject to change at any time without notice. For the current locations of Plan Hospitals, please call our Member Service Contact Center.

Plan Medical Office: Any medical office listed in the "Plan Facilities" section or in a Kaiser Permanente guidebook *(Your Guidebook)* for our Service Area, except that Plan Medical Offices are subject to change at any time without notice. For the current locations of Plan Medical Offices, please call our Member Service Contact Center.

Plan Optical Sales Office: An optical sales office owned and operated by Kaiser Permanente or another optical sales office that we designate. Please refer to *Your Guidebook* for a list of Plan Optical Sales Offices in your area, except that Plan Optical Sales Offices are subject to change at any time without notice. For the current locations of Plan Optical Sales Offices, please call our Member Service Contact Center.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Please refer to *Your Guidebook* for a list of Plan Pharmacies in your area, except that Plan Pharmacies are subject to change at any time without notice. For the current locations of Plan Pharmacies, please call our Member Service Contact Center.

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

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

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

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that this condition is Stabilized.

Premiums: The periodic amounts that your Group is responsible for paying for your membership under this *Evidence of Coverage*, except that you are responsible for paying Premiums if you have Cal-COBRA coverage.

Preventive Care Services: Services that do one or more of the following:

- Protect against disease, such as in the use of immunizations
- Promote health, such as counseling on tobacco use
- Detect disease in its earliest stages before noticeable symptoms develop, such as screening for breast cancer

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Please refer to our website at **kp.org** for a directory of Primary Care Physicians, except that the directory is subject to change without notice. For the current list of physicians that are available as Primary Care Physicians, please call the personal physician selection department at the phone number listed in *Your Guidebook*.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. For information about Region locations in the District of Columbia and parts of Southern California, Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington, please call our Member Service Contact Center.

Service Area: The ZIP codes below for each county are in our Service Area:

- All ZIP codes in Alameda County are inside our Service Area: 94501–02, 94514, 94536–46, 94550–52, 94555, 94557, 94560, 94566, 94568, 94577–80, 94586–88, 94601–15, 94617–21, 94622–24, 94649, 94659–62, 94666, 94701–10, 94712, 94720, 95377, 95391
- The following ZIP codes in Amador County are inside our Service Area: 95640, 95669
- All ZIP codes in Contra Costa County are inside our Service Area: 94505–07, 94509, 94511, 94513–14, 94516–31, 94547–49, 94551, 94553, 94556, 94561, 94563–65, 94569–70, 94572, 94575, 94582–83, 94595–98, 94706–08, 94801–08, 94820, 94850

- The following ZIP codes in El Dorado County are inside our Service Area: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762
- The following ZIP codes in Fresno County are inside our Service Area: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–30, 93737, 93740–41, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–79, 93786, 93790–94, 93844, 93888
- The following ZIP codes in Kings County are inside our Service Area: 93230, 93232, 93242, 93631, 93656
- The following ZIP codes in Madera County are inside our Service Area: 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720
- All ZIP codes in Marin County are inside our Service Area: 94901, 94903–04, 94912–15, 94920, 94924–25, 94929–30, 94933, 94937–42, 94945–50, 94956–57, 94960, 94963–66, 94970–71, 94973–74, 94976–79
- The following ZIP codes in Mariposa County are inside our Service Area: 93601, 93623, 93653
- The following ZIP codes in Napa County are inside our Service Area: 94503, 94508, 94515, 94558–59, 94562, 94567 (except that Knoxville is not in our Service Area), 94573–74, 94576, 94581, 94589–90, 94599, 95476
- The following ZIP codes in Placer County are inside our Service Area: 95602–04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95692, 95703, 95722, 95736, 95746–47, 95765
- All ZIP codes in Sacramento County are inside our Service Area: 94203–09, 94211, 94229–30, 94232, 94234–37, 94239–40, 94244, 94246–50, 94252, 94254, 94256–59, 94261–63, 94267–69, 94271, 94273–74, 94277–80, 94282–91, 94293–98, 94571, 95608–11, 95615, 95621, 95624, 95626, 95628, 95630, 95632, 95638–41, 95652, 95655, 95660, 95662, 95670–71, 95673, 95680, 95683, 95690, 95693, 95741–42, 95757–59, 95763, 95811–38, 95840–43, 95851–53, 95860, 95864–67, 95887, 95894, 95899
- All ZIP codes in San Francisco County are inside our Service Area: 94102–05, 94107–12, 94114–27, 94129–34, 94137, 94139–47, 94151, 94156, 94158–64, 94172, 94177, 94188
- All ZIP codes in San Joaquin County are inside our Service Area: 94514, 95201–13, 95215, 95219–20, 95227, 95230–31, 95234, 95236–37, 95240–42, 95253, 95258, 95267, 95269, 95296–97, 95304, 95320, 95330, 95336–37, 95361, 95366, 95376–78, 95385, 95391, 95632, 95686, 95690
- All ZIP codes in San Mateo County are inside our Service Area: 94002, 94005, 94010–11, 94014–21, 94025–28, 94030, 94037–38, 94044, 94060–66, 94070, 94074, 94080, 94083, 94128, 94303, 94401–04, 94497
- The following ZIP codes in Santa Clara County are inside our Service Area: 94022–24, 94035, 94039–43, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–36, 95138–41, 95148, 95150–61, 95164, 95170, 95172–73, 95190–94, 95196
- All ZIP codes in Solano County are inside our Service Area: 94510, 94512, 94533–35, 94571, 94585, 94589–92, 95616, 95620, 95625, 95687–88, 95690, 95694, 95696
- The following ZIP codes in Sonoma County are inside our Service Area: 94515, 94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, 95492
- All ZIP codes in Stanislaus County are inside our Service Area: 95230, 95304, 95307, 95313, 95316, 95319, 95322–23, 95326, 95328–29, 95350–58, 95360–61, 95363, 95367–68, 95380–82, 95385–87, 95397
- The following ZIP codes in Sutter County are inside our Service Area: 95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 95836–37
- The following ZIP codes in Tulare County are inside our Service Area: 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
- The following ZIP codes in Yolo County are inside our Service Area: 95605, 95607, 95612, 95616–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99
- The following ZIP codes in Yuba County are inside our Service Area: 95692, 95903, 95961

For each ZIP code listed for a county, our Service Area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside our Service Area unless that other county is listed above and that ZIP code is also listed for that other county. If you have a question about whether a ZIP code

is in our Service Area, please call our Member Service Contact Center.

Note: We may expand our Service Area at any time by giving written notice to your Group. ZIP codes are subject to change by the U.S. Postal Service.

Services: Health care services or items ("health care" includes both physical health care and mental health care) and behavioral health treatment covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the "Benefits and Cost Sharing" section.

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

Spouse: The Subscriber's legal husband or wife. For the purposes of this *Evidence of Coverage*, the term "Spouse" includes the Subscriber's same-sex spouse if the Subscriber and spouse are a couple who meet all of the requirements of Section 308(c) of the California Family Code, or the Subscriber's registered domestic partner who meets all of the requirements of Sections 297 or 299.2 of the California Family Code. If your Group allows enrollment of domestic partners who do not meet all of the requirements of Sections 297 or 299.2 of the California Family Code, the term "Spouse" also includes the Subscriber's domestic partner who meets your Group's eligibility requirements for domestic partners.

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

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

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

Premiums, Eligibility, and Enrollment

Premiums

Your Group is responsible for paying Premiums, except that you are responsible for paying Premiums as described in the "Continuation of Membership" section if you have Cal-COBRA coverage under this *Evidence of Coverage*. If you are responsible for any contribution to the Premiums that your Group pays, your Group will tell you the amount and how to pay your Group (through payroll deduction, for example).

Who Is Eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this "Who Is Eligible" section.

Group eligibility requirements

You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of its eligibility requirements, such as the minimum number of hours that employees must work.

Health Plan eligibility requirements

If you commit any of the following acts, you are not eligible to continue enrollment:

- Your behavior threatens the safety of Plan personnel or of any person or property at a Plan Facility
- You commit theft from Health Plan, from a Plan Provider, or at a Plan Facility

Service Area eligibility requirements

The "Definitions" section describes our Service Area and how it may change.

Subscribers must live or work inside our Service Area at the time they enroll. If after enrollment the Subscriber no longer lives or works inside our Service Area, the Subscriber can continue membership unless (1) he or she lives inside or moves to the service area of another Region and does not work inside our Service Area, or (2) your Group does not allow continued enrollment of

Subscribers who do not live or work inside our Service Area.

Dependent children of the Subscriber or of the Subscriber's Spouse may live anywhere inside or outside our Service Area. Other Dependents may live anywhere, except that they are not eligible to enroll or to continue enrollment if they live in or move to the service area of another Region.

If you are not eligible to continue enrollment because you live in or move to the service area of another Region, please contact your Group to learn about your Group health care options:

- **Regions outside California.** You may be able to enroll in the service area of another Region if there is an agreement between your Group and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same. For the purposes of this eligibility rule, the Regions outside California may change on January 1 of each year and are currently the District of Columbia and parts of Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington
- **Southern California Region's service area.** Your Group may have an arrangement with us that permits membership in the Southern California Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *Evidence of Coverage.* All terms and conditions in your application for enrollment in the Northern California Region, including the Arbitration Agreement, will continue to apply if the Subscriber does not submit a new enrollment form

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

Additional eligibility requirements

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

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

If you are a Subscriber under this *Evidence of Coverage* (or if you are a subscriber under Kaiser Permanente Senior Advantage or one of our other plans that your Group offers that requires members to have Medicare) and if your Group allows enrollment of Dependents, the following persons may be eligible to enroll as your Dependents under this *Evidence of Coverage* (Dependent children are eligible through the end of the year in which they reach the age limit for Dependents):

- Your Spouse. For the purposes of this *Evidence of Coverage*, the term "Spouse" includes the Subscriber's same-sex spouse if the Subscriber and spouse are a couple who meet all of the requirements of Section 308(c) of the California Family Code, or your registered domestic partner who meets all of the requirements of Sections 297 or 299.2 of the California Family Code. If your Group allows enrollment of domestic partners who do not meet all of the requirements of Sections 297 or 299.2 of the California Family Code, the term "Spouse" also includes your domestic partner who meets your Group's eligibility requirements for domestic partners
- Your or your Spouse's children (including adopted children or children placed with you or your Spouse for adoption) who are under age 26
- Children (not including foster children) for whom you or your Spouse is the court-appointed guardian (or was when the person reached age 18) if they are under age 26
- Children whose parent is a Dependent under your family coverage (including adopted children or children placed with your Dependent for adoption, but not including foster children) if they meet all of the following requirements:
  - they are not married and do not have a domestic partner (for the purposes of this requirement only, "domestic partner" means someone who is a registered domestic partner in California or who is legally recognized as a domestic partner in the state where the couple resides)
  - they are under age 26
  - they receive all of their support and maintenance from you or your Spouse
  - they permanently reside with you or your Spouse
- Dependents who meet the Dependent eligibility requirements, except for the age limit, are eligible as disabled dependents if they meet all of the following requirements:
  - your Group permits enrollment of dependent children
  - they are your or your Spouse's children, your or your Spouse's adopted children, children placed with you or your Spouse for adoption, or children for whom you or your Spouse is the legal guardian
  - they are incapable of self-sustaining employment because of a physically- or mentally-disabling

injury, illness, or condition that occurred before they reached the age limit for Dependents

- they receive 50 percent or more of their support and maintenance from you or your Spouse
- you give us proof of their incapacity and dependency within 60 days after we request it (see "Disabled dependent certification" below in this "Additional eligibility requirements" section)

Note: If you are a subscriber under Kaiser Permanente Senior Advantage or one of our other plans that requires members to have Medicare, all of your dependents who are enrolled under this or any other non-Medicare evidence of coverage offered by your Group must be enrolled under the same non-Medicare evidence of coverage. A "non-Medicare" evidence of coverage is one that does not require members to have Medicare.

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

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

Persons barred from enrolling

You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause or if you have ever lost eligibility for Health Plan coverage for a reason described under "Health Plan eligibility requirements" in this "Who Is Eligible" section.

Members with Medicare and retirees

This *Evidence of Coverage* is not intended for most Medicare beneficiaries and some Groups do not offer coverage to retirees. If, during the term of this *Evidence of Coverage*, you are (or become) eligible for Medicare (please see "Medicare" in the "Definitions" section for the meaning of "eligible for" Medicare) or you retire, please ask your Group about your membership options as follows:

- If a Subscriber who has Medicare Part B retires and the Subscriber's Group has a Kaiser Permanente Senior Advantage plan for retirees, the Subscriber should enroll in the plan if eligible
- If the Subscriber has dependents who have Medicare and your Group has a Kaiser Permanente Senior Advantage plan (or of one our other plans that require members to have Medicare), the Subscriber may be able to enroll them as dependents under that plan
- If the Subscriber retires and your Group does not offer coverage to retirees, you may be eligible to continue membership as described in the "Continuation of Membership" section
- If federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary, your coverage under this *Evidence of Coverage* will be the same as it would be if you had not become eligible for Medicare. However, you may also be eligible to enroll in Kaiser Permanente Senior Advantage through your Group if you have Medicare Part B
- If you are (or become) eligible for Medicare and are in a class of beneficiaries for which your Group's health care coverage is secondary to Medicare, you should consider enrollment in Kaiser Permanente Senior Advantage through your Group if you are eligible

- If none of the above applies to you and you are eligible for Medicare or you retire, please ask your Group about your membership options

Note: If you are enrolled in a Medicare plan and lose Medicare eligibility, you may be able to enroll under this *Evidence of Coverage* if permitted by your Group (please ask your Group for details).

When Medicare is primary. Your Group's Premiums may increase if you are (or become) eligible for Medicare Part A or B as primary coverage, and you are not enrolled through your Group in Kaiser Permanente Senior Advantage for any reason (even if you are not eligible to enroll or the plan is not available to you).

When Medicare is secondary. Medicare is the primary coverage except when federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary. Members who have Medicare when Medicare is secondary by law are subject to the same Premiums and receive the same benefits as Members who are under age 65 and do not have Medicare. In addition, any such Member for whom Medicare is secondary by law and who meets the eligibility requirements for the Kaiser Permanente Senior Advantage plan applicable when Medicare is secondary may also enroll in that plan if it is available. These Members receive the benefits and coverage described in this *Evidence of Coverage* and the Kaiser Permanente Senior Advantage evidence of coverage applicable when Medicare is secondary.

Medicare late enrollment penalties. If you become eligible for Medicare Part B and do not enroll, Medicare may require you to pay a late enrollment penalty if you later enroll in Medicare Part B. However, if you delay enrollment in Part B because you or your husband or wife are still working and have coverage through an employer group health plan, you may not have to pay the penalty. Also, if you are (or become) eligible for Medicare and go without creditable prescription drug coverage (drug coverage that is at least as good as the standard Medicare Part D prescription drug coverage) for a continuous period of 63 days or more, you may have to pay a late enrollment penalty if you later sign up for Medicare prescription drug coverage. If you are (or become) eligible for Medicare, your Group is responsible for informing you about whether your drug coverage under this *Evidence of Coverage* is creditable prescription drug coverage at the times required by the Centers for Medicare & Medicaid Services and upon your request.

Capacity limit. You may be ineligible to enroll in Kaiser Permanente Senior Advantage if that plan has reached a capacity limit that the Centers for Medicare & Medicaid Services has approved. This limitation does not apply if you are currently a Health Plan Member in the Northern California or Southern California Region who is eligible for Medicare (for example, when you turn age 65).

When You Can Enroll and When Coverage Begins

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

If you are eligible to be a Dependent under this *Evidence of Coverage* but the subscriber in your family is enrolled under a Kaiser Permanente Senior Advantage evidence of coverage offered by your Group (or an evidence of coverage for one of our other plans that your Group offers that requires members to have Medicare), the rules for enrollment of Dependents in this "When You Can Enroll and When Coverage Begins" section apply, not the rules for enrollment of dependents in the subscriber's evidence of coverage.

New employees

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

Effective date of coverage. The effective date of coverage for new employees and their eligible family Dependents is the date of hire.

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 a Health Plan–approved change of enrollment form to your Group within 31 days after the Dependent first becomes eligible.

Effective date of coverage. The effective date of coverage for newly acquired Dependents is as follows:

- For a newborn child, coverage is effective from the moment of birth. However, if you do not enroll the newborn child within 31 days, the newborn is covered for only 31 days (including the date of birth)
- For a newly adopted child or child placed with you or your Spouse for adoption, coverage is effective on the date when you or your Spouse gain the legal right to control the child's health care. For purposes of this requirement, "legal right to control health care" means you have a signed written document (such as a health facility minor release report, a medical authorization form, or a relinquishment form) or other evidence that shows you or your Spouse have the legal right to control the child's health care
- For all other newly acquired Dependents, the effective date of coverage is the date of acquisition

Open enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan–approved enrollment application to your Group during your Group's open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the effective date of coverage.

Special enrollment

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

- You become eligible as described in this "Special enrollment" section
- You did not enroll in any coverage offered by your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. The effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application from the Subscriber

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

The effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber. Enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, adoption, or placement for adoption.

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

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

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

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 30 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for Medicaid, Children's Health Insurance Program, or Access for Infants and Mothers Program coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

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

The effective date of coverage resulting from a court or administrative order is the first of the month following the date we receive the enrollment request, unless your Group specifies a different effective date (if your Group specifies a different effective date, the effective date cannot be earlier than the date of the order).

Special enrollment due to eligibility for premium assistance. You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, if you or a dependent become eligible for premium assistance through the Medi-Cal program. Premium assistance is when the Medi-Cal program pays all or part of premiums for employer group coverage for a Medi-Cal beneficiary. To request enrollment in your Group's health care coverage, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 60 days after you or a dependent become eligible for premium assistance. Please contact the California Department of Health Care Services to find out if premium assistance is available and the eligibility requirements.

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

How to Obtain Services

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

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Cost Sharing" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Hospice care as described under "Hospice Care" in the "Benefits and Cost Sharing" section

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

Routine Care

If you need the following Services, you should schedule an appointment:

- Preventive Care Services
- Periodic follow-up care (regularly scheduled follow-up care, such as visits to monitor a chronic condition)
- Other care that is not Urgent Care

To make a non-urgent appointment, please refer to *Your Guidebook* for appointment telephone numbers, or go to our website at **kp.org** to request an appointment online.

Urgent Care

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice telephone number at a Plan Facility. Please refer to *Your Guidebook* for appointment and advice telephone numbers.

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

Not Sure What Kind of Care You Need?

Sometimes it's difficult to know what kind of care you need, so we have licensed health care professionals available to assist you by phone 24 hours a day, seven days a week. Here are some of the ways they can help you:

- They can answer questions about a health concern, and instruct you on self-care at home if appropriate
- They can advise you about whether you should get medical care, and how and where to get care (for example, if you are not sure whether your condition is

an Emergency Medical Condition, they can help you decide whether you need Emergency Services or Urgent Care, and how and where to get that care)

- They can tell you what to do if you need care and a Plan Medical Office is closed

You can reach one of these licensed health care professionals by calling the appointment or advice telephone number listed in *Your Guidebook*. When you call, a trained support person may ask you questions to help determine how to direct your call.

Your Personal Plan Physician

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

We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal Plan Physicians.

To learn how to select a personal Plan Physician, please refer to *Your Guidebook* or call our Member Service Contact Center. You can find a directory of our Plan Physicians on our website at **kp.org**. For the current list of physicians that are available as Primary Care Physicians, please call the personal physician selection department at the phone number listed in *Your Guidebook*. You can change your personal Plan Physician for any reason.

Getting a Referral

Referrals to Plan Providers

A Plan Physician must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, urology, dermatology, and physical, occupational, and speech therapies. Also, a Plan Physician must refer you before you can get care from Qualified Autism Service Providers covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the "Benefits and Cost Sharing" section. However, you do not need a referral or prior authorization to receive most care from any of the following Plan Providers:

- Your personal Plan Physician
- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, psychiatry, chemical dependency, and obstetrics/gynecology

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

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

Medical Group authorization procedure for certain referrals

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

- **Durable medical equipment.** If your Plan Physician prescribes durable medical equipment, he or she will submit a written referral to the Plan Hospital's durable medical equipment coordinator, who will authorize the durable medical equipment if he or she determines that your durable medical equipment coverage includes the item and that the item is listed on our formulary for your condition. If the item doesn't appear to meet our durable medical equipment formulary guidelines, then the durable medical equipment coordinator will contact the Plan Physician for additional information. If the durable medical equipment request still doesn't appear to meet our durable medical equipment formulary guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our durable medical equipment formulary, please refer to "Durable Medical Equipment for Home Use" in the "Benefits and Cost Sharing" section
- **Ostomy and urological supplies.** If your Plan Physician prescribes ostomy or urological supplies, he or she will submit a written referral to the Plan Hospital's designated coordinator, who will authorize the item if he or she determines that it is covered and the item is listed on our soft goods formulary for your

condition. If the item doesn't appear to meet our soft goods formulary guidelines, then the coordinator will contact the Plan Physician for additional information. If the request still doesn't appear to meet our soft goods formulary guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our soft goods formulary, please refer to "Ostomy and Urological Supplies" in the "Benefits and Cost Sharing" section

- **Services not available from Plan Providers.** If your Plan Physician decides that you require covered Services not available from Plan Providers, he or she will recommend to the Medical Group that you be referred to a Non–Plan Provider inside or outside our Service Area. The appropriate Medical Group designee will authorize the Services if he or she determines that they are Medically Necessary and are not available from a Plan Provider. Referrals to Non–Plan Physicians will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your Plan Physician what Services have been authorized
- **Transplants.** If your Plan Physician makes a written referral for a transplant, the Medical Group's regional transplant advisory committee or board (if one exists) will authorize the Services if it determines that they are Medically Necessary. In cases where no transplant committee or board exists, the Medical Group will refer you to physician(s) at a transplant center, and the Medical Group will authorize the Services if the transplant center's physician(s) determine that they are Medically Necessary. Note: A Plan Physician may provide or authorize a corneal transplant without using this Medical Group transplant authorization procedure

Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

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

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your physician will be informed of the scope of the authorized Services. If the Medical Group does not authorize all of the Services, Health Plan will send you a written decision and explanation within two business days after the decision is made. The letter will include information about your appeal rights, which are described in the "Dispute Resolution" section. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request.

Cost Sharing. The Cost Sharing for these referral Services is the Cost Sharing required for Services provided by a Plan Provider as described in the "Benefits and Cost Sharing" section.

More information. This description is only a brief summary of the authorization procedure. The policies and procedures (including a description of the authorization procedure or information about the authorization procedure applicable to some Plan Providers other than Kaiser Foundation Hospitals and the Medical Group) are available upon request from our Member Service Contact Center. Please refer to "Post-Stabilization Care" under "Emergency Services" in the "Emergency Services and Urgent Care" section for authorization requirements that apply to Post-Stabilization Care from Non–Plan Providers.

Completion of Services from Non–Plan Providers

New Member. If you are currently receiving Services from a Non–Plan Provider in one of the cases listed below under "Eligibility" and your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective, you may be eligible for limited coverage of that Non–Plan Provider's Services.

Terminated provider. If you are currently receiving covered Services in one of the cases listed below under "Eligibility" from a Plan Hospital or a Plan Physician (or certain other providers) when our contract with the provider ends (for reasons other than medical disciplinary cause or criminal activity), you may be eligible for limited coverage of that terminated provider's Services.

Eligibility. The cases that are subject to this completion of Services provision are:

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration. We may cover these Services until the acute condition ends
- We may cover Services for serious chronic conditions until the earlier of (1) 12 months from your effective date of coverage if you are a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non–Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
  - it persists without full cure
  - it worsens over an extended period of time
  - it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Care for children under age 3. We may cover completion of these Services until the earlier of (1) 12 months from the child's effective date of coverage if the child is a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the child's third birthday
- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of your effective date of coverage if you are a new Member or within 180 days of the termination date of the terminated provider

To qualify for this completion of Services coverage, all of the following requirements must be met:

- Your Health Plan coverage is in effect on the date you receive the Service
- For new Members, your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective
- You are receiving Services in one of the cases listed above from a Non–Plan Provider on your effective date of coverage if you are a new Member, or from the terminated Plan Provider on the provider's termination date
- For new Members, when you enrolled in Health Plan, you did not have the option to continue with your previous health plan or to choose another plan (including an out-of-network option) that would cover the Services of your current Non–Plan Provider
- The provider agrees to our standard contractual terms and conditions, such as conditions pertaining to payment and to providing Services inside our Service Area
- The Services to be provided to you would be covered Services under this *Evidence of Coverage* if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from your effective date of coverage if you are a new Member or from the termination date of the Plan Provider

Cost Sharing. The Cost Sharing for completion of Services is the Cost Sharing required for Services provided by a Plan Provider as described in the "Benefits and Cost Sharing" section.

More information. For more information about this provision, or to request the Services or a copy of our "Completion of Covered Services" policy, please call our Member Service Contact Center.

Second Opinions

If you want a second opinion, you can either ask your Plan Physician to help you arrange one, or you can make an appointment with another Plan Physician. If there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, the appropriate Medical Group designee will authorize a consultation with a non-Plan Physician for a second opinion. For purposes of this "Second Opinions" provision, an "appropriately qualified medical professional" is a physician who is acting within his or her scope of practice and who possesses a clinical background related to the illness or condition associated with the request for a second medical opinion.

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

- Your Plan Physician has recommended a procedure and you are unsure about whether the procedure is reasonable or necessary

- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions
- The clinical indications are not clear or are complex and confusing
- A diagnosis is in doubt due to conflicting test results
- The Plan Physician is unable to diagnose the condition
- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have concerns about the diagnosis or plan of care

Cost Sharing. The Cost Sharing for these referral Services is the Cost Sharing required for Services provided by a Plan Provider as described in the "Benefits and Cost Sharing" section.

Contracts with Plan Providers

How Plan Providers are paid

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

Financial liability

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

Termination of a Plan Provider's contract

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements. You may be eligible to receive Services from a terminated provider; please refer to "Completion of Services from Non–Plan Providers" under "Getting a Referral" in this "How to Obtain Services" section.

Provider groups and hospitals. If you are assigned to a provider group or hospital whose contract with us terminates, or if you live within 15 miles of a hospital whose contract with us terminates, we will give you written notice at least 60 days before the termination (or as soon as reasonably possible).

Visiting Other Regions

If you visit the service area of another Region temporarily (not more than 90 days), you can receive visiting member care from designated providers in that area. Visiting member care is described in our visiting member brochure. Visiting member care and your out-of-pocket costs may differ from the covered Services and Cost Sharing described in this *Evidence of Coverage*.

The 90-day limit on visiting member care does not apply to Members who attend an accredited college or accredited vocational school. The service areas and facilities where you may obtain visiting member care may change at any time without notice.

Please call our Member Service Contact Center for more information about visiting member care, including facility locations in the service area of another Region, and to request a copy of the visiting member brochure.

Your ID Card

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

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

Getting Assistance

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

who are treating you. They are committed to your satisfaction and want to help you with your questions.

Member Services

Many Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Contact Center representatives are available to assist you toll free at 1-800-464-4000 or 1-800-777-1370 (TTY for the deaf, hard of hearing, or speech impaired) 24 hours a day, seven days a week (except holidays, and after 5 p.m. the day after Thanksgiving, Christmas Eve, and New Year's Eve). For your convenience, you can also contact us through our website at **kp.org**.

Member Services representatives at our Plan Facilities and Member Service Contact Center can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace your ID card. These representatives can also help you if you need to file a claim as described in the "Emergency Services and Urgent Care" section or with any issues as described in the "Dispute Resolution" section.

If you have questions about a bill or about how much you have paid toward your Deductible or annual out-of-pocket maximum, or to get an estimate of Charges for Services that are subject to the Deductible, please call our Member Service Contact Center weekdays from 7 a.m. to 5 p.m. toll free at 1-800-390-3507 (TTY users call 1-800-777-1370). You can also get an estimate of Charges for Services through our website at **kp.org**.

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services are available 24 hours a day, seven days a week, at no cost to you. For more information on the interpreter services we offer, please call our Member Service Contact Center.

Plan Facilities

At most of our Plan Facilities, you can usually receive all of the covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you:

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available from Plan Hospital Emergency Departments as described in *Your Guidebook* (please refer to *Your Guidebook* for Emergency Department locations in your area)
- Same–day Urgent Care appointments are available at many locations (please refer to *Your Guidebook* for Urgent Care locations in your area)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services Department (refer to *Your Guidebook* for locations in your area)

Plan Hospitals and Plan Medical Offices

The following is a list of Plan Hospitals and most Plan Medical Offices in our Service Area. Please refer to *Your Guidebook* for the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services. Additional Plan Medical Offices are listed in *Your Guidebook* and on our website at **kp.org**. This list is subject to change at any time without notice. If there is a change to this list of Plan Facilities, we will update this list in any Plan evidence of coverage issued after that date. If you have any questions about the current locations of Plan Facilities, please call our Member Service Contact Center.

Alameda

- Medical Offices: 2417 Central Ave.

Antioch

- Hospital and Medical Offices: 4501 Sand Creek Rd.
- Medical Offices: 3400 Delta Fair Blvd.

Campbell

- Medical Offices: 220 E. Hacienda Ave.

Clovis

- Medical Offices: 2071 Herndon Ave.

Daly City

- Medical Offices: 395 Hickey Blvd.

Davis

- Medical Offices: 1955 Cowell Blvd.

Elk Grove

- Medical Offices: 9201 Big Horn Blvd.

Fairfield

- Medical Offices: 1550 Gateway Blvd.

Folsom

- Medical Offices: 2155 Iron Point Rd.

Fremont

- Hospital and Medical Offices: 39400 Paseo Padre Pkwy.

Fresno

- Hospital and Medical Offices: 7300 N. Fresno St.

Gilroy

- Medical Offices: 7520 Arroyo Circle

Hayward

- Hospital and Medical Offices: 27400 Hesperian Blvd.

Lincoln

- Medical Offices: 1900 Dresden Dr.

Livermore

- Medical Offices: 3000 Las Positas Rd.

Manteca

- Hospital and Medical Offices: 1777 W. Yosemite Ave.
- Medical Offices: 1721 W. Yosemite Ave.

Martinez

- Medical Offices: 200 Muir Rd.

Milpitas

- Medical Offices: 770 E. Calaveras Blvd.

Modesto

- Hospital and Medical Offices: 4601 Dale Rd.
- Medical Offices: 3800 Dale Rd.
- Please refer to *Your Guidebook* for other Plan Providers in Stanislaus County

Mountain View

- Medical Offices: 555 Castro St.

Napa

- Medical Offices: 3285 Claremont Way

Novato

- Medical Offices: 97 San Marin Dr.

Oakhurst

- Medical Offices: 40595 Westlake Dr.

Oakland

- Hospital and Medical Offices: 280 W. MacArthur Blvd.

Petaluma

- Medical Offices: 3900 Lakeville Hwy.

Pinole

- Medical Offices: 1301 Pinole Valley Rd.

Pleasanton

- Medical Offices: 7601 Stoneridge Dr.

Rancho Cordova

- Medical Offices: 10725 International Dr.

Redwood City

- Hospital and Medical Offices: 1150 Veterans Blvd.

Richmond

- Hospital and Medical Offices: 901 Nevin Ave.

Rohnert Park

- Medical Offices: 5900 State Farm Dr.

Roseville

- Hospital and Medical Offices: 1600 Eureka Rd.
- Medical Offices: 1001 Riverside Ave.

Sacramento

- Hospitals and Medical Offices: 2025 Morse Ave. and 6600 Bruceville Rd.
- Medical Offices: 1650 Response Rd. and 2345 Fair Oaks Blvd.

San Bruno

- Medical Offices: 901 El Camino Real

San Francisco

- Hospital and Medical Offices: 2425 Geary Blvd.

San Jose

- Hospital and Medical Offices: 250 Hospital Pkwy.

San Mateo

- Medical Offices: 1000 Franklin Pkwy.

San Rafael

- Hospital and Medical Offices: 99 Montecillo Rd.
- Medical Offices: 1033 3rd St.

Santa Clara

- Hospital and Medical Offices: 700 Lawrence Expwy.

Santa Rosa

- Hospital and Medical Offices: 401 Bicentennial Way

Selma

- Medical Offices: 2651 Highland Ave.

South San Francisco

- Hospital and Medical Offices: 1200 El Camino Real

Stockton

- Hospital: 525 W. Acacia St. (Dameron Hospital)
- Medical Offices: 7373 West Ln.

Tracy

- Medical Offices: 2185 W. Grant Line Rd.

Turlock

- Hospital: 825 Delbon Ave. (Emanuel Medical Center)

Union City

- Medical Offices: 3553 Whipple Rd.

Vacaville

- Hospital and Medical Offices: 1 Quality Dr.

Vallejo

- Hospital and Medical Offices: 975 Sereno Dr.

Walnut Creek

- Hospital and Medical Offices: 1425 S. Main St.
- Medical Offices: 320 Lennon Ln.

Note: State law requires evidence of coverage documents to include the following notice: "Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the Kaiser Permanente Member Service Contact Center, to ensure that you can obtain the health care services that you need."

Please be aware that if a Service is covered but not available at a particular Plan Facility, we will make it available to you at another facility.

Your Guidebook to Kaiser Permanente Services (Your Guidebook)

Plan Medical Offices and Plan Hospitals for your area are listed in greater detail in *Your Guidebook to Kaiser Permanente Services (Your Guidebook)*. *Your Guidebook* describes the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services. It includes additional facilities that are not listed in this "Plan Facilities" section. Also, it explains how to use our Services and make appointments, lists hours of operation, and includes a detailed telephone directory for appointments and advice. *Your Guidebook* provides other important information, such as preventive care guidelines and your Member rights and responsibilities. *Your Guidebook* is subject to change and is periodically updated. You can get a copy by visiting our website at **kp.org** or by calling our Member Service Contact Center.

Emergency Services and Urgent Care

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital Emergency Department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non–Plan Providers anywhere in the world as long as the Services would have been covered under the "Benefits and Cost Sharing" section (subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section) if you had received them from Plan Providers.

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

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that this condition is Stabilized. We cover Post-Stabilization Care from a Non–Plan Provider, including inpatient care at a Non–Plan Hospital, only if we provide prior authorization for the care or if otherwise required by applicable law ("prior authorization" means that we must approve the Services in advance).

To request authorization to receive Post-Stabilization Care from a Non–Plan Provider, you must call us toll free at **1-800-225-8883** (TTY users call 711) or the notification telephone number on your Kaiser Permanente ID card *before* you receive the care if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible). After we are notified, we will

discuss your condition with the Non–Plan Provider. If we decide that you require Post-Stabilization Care and that this care would be covered if you received it from a Plan Provider, we will authorize your care from the Non–Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated Non–Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered.

Be sure to ask the Non–Plan Provider to tell you what care (including any transportation) we have authorized because we will not cover unauthorized Post-Stabilization Care or related transportation provided by Non–Plan Providers.

We understand that extraordinary circumstances can delay your ability to call us to request authorization for Post-Stabilization Care from a Non–Plan Provider, for example, if a young child is without a parent or guardian present, or you are unconscious. In these cases, you must call us as soon as reasonably possible. Please keep in mind that anyone can call us for you. We do not cover any care you receive from Non–Plan Providers after your Emergency Medical Condition is Stabilized unless we authorize it, so if you don't call as soon as reasonably possible, you increase the risk that you will have to pay for this care.

Cost Sharing

The Cost Sharing for covered Emergency Services and Post-Stabilization Care is the Cost Sharing required for Services provided by Plan Providers as described in the "Benefits and Cost Sharing" section:

- Please refer to "Outpatient Care" for the Cost Sharing for Emergency Department visits
- The Cost Sharing for other covered Emergency Services and Post-Stabilization Care is the Cost Sharing that you would pay if the Services were not Emergency Services or Post-Stabilization Care. For example, if you are admitted as an inpatient to a Non–Plan Hospital for Post-Stabilization Care and we give prior authorization for that care, your Cost Sharing would be the Cost Sharing listed under "Hospital Inpatient Care"

Services not covered under this "Emergency Services" section

Coverage for the following Services is described in other sections of this *Evidence of Coverage*:

- Follow-up care and other Services that are not Emergency Services or Post-Stabilization Care described in this "Emergency Services" section (refer to the "Benefits and Cost Sharing" section for coverage, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- Out-of-Area Urgent Care (refer to "Out-of-Area Urgent" care under "Urgent Care" in this "Emergency Services and Urgent Care" section)

Urgent Care

Inside the Service Area

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice telephone number at a Plan Facility. Please refer to *Your Guidebook* for appointment and advice telephone numbers.

Out-of-Area Urgent Care

If you have an Urgent Care need due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), we cover Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health from a Non–Plan Provider if all of the following are true:

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

You do not need prior authorization for Out-of-Area Urgent Care. We cover Out-of-Area Urgent Care you receive from Non–Plan Providers as long as the Services would have been covered under the "Benefits and Cost Sharing" section (subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section) if you had received them from Plan Providers.

Cost Sharing

The Cost Sharing for covered Urgent Care is the Cost Sharing required for Services provided by Plan Providers as described in the "Benefits and Cost Sharing" section:

- Please refer to "Outpatient Care" for the Cost Sharing for Urgent Care consultations, exams, and treatment
- The Cost Sharing for other covered Urgent Care is the Cost Sharing that you would pay if the Services were not Urgent Care. For example, if the Urgent Care you receive includes an X-ray, your Cost Sharing for the X-ray would be the Cost Sharing for an X-ray listed under "Outpatient Imaging, Laboratory, and Special Procedures"

Services not covered under this "Urgent Care" section

Coverage for the following Services is described in other sections of this *Evidence of Coverage*:

- Follow-up care and other Services that are not Urgent Care or Out-of-Area Urgent Care described in this "Urgent Care" section (refer to the "Benefits and Cost Sharing" section for coverage, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider as described in this "Emergency Services and Urgent Care" section, or emergency ambulance Services described under "Ambulance Services" in the "Benefits and Cost Sharing" section, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us. Also, you may be required to pay and file a claim for any Services prescribed by a Non–Plan Provider as part of covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care even if you receive the Services from a Plan Provider, such as a Plan Pharmacy.

For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Benefits and Cost Sharing

We cover the Services described in this "Benefits and Cost Sharing" section, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section, only if all of the following conditions are satisfied:

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
  - health care items and services for preventive care
  - health care items and services for diagnosis, assessment, or treatment
  - health education covered under "Health Education" in this "Benefits and Cost Sharing" section
  - other health care items and services
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except where specifically noted to the contrary in the sections listed below for the following Services:
  - drugs prescribed by dentists as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section
  - emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- You receive the Services from Plan Providers inside our Service Area, except where specifically noted to the contrary in the sections listed below for the following Services:
  - authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
  - emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
  - hospice care as described under "Hospice Care" in this "Benefits and Cost Sharing" section
- The Medical Group has given prior authorization for the Services if required under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

The only Services we cover under this *Evidence of Coverage* are those that this "Benefits and Cost Sharing" section says that we cover, subject to exclusions and limitations described in this "Benefits and Cost Sharing" section and to all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. The "Exclusions, Limitations, Coordination of Benefits, and Reductions" section describes exclusions, limitations, reductions, and coordination of benefits provisions that apply to all Services that would otherwise be covered. When an exclusion or limitation applies only to a particular benefit, it is listed in the description of that benefit in this "Benefits and Cost Sharing" section. Also, please refer to:

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

Cost Sharing

General rules, examples, and exceptions

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

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

Cost Sharing for Services received by newborns. During the 31 days of automatic coverage for newborn children described under "Adding new Dependents to an existing account" under "When You Can Enroll and When Coverage Begins" in the "Premiums, Eligibility, and Enrollment" section the parent or guardian of the baby must pay the Cost Sharing indicated in this "Benefits and Cost Sharing" section for any Services that the baby receives, whether or not the baby is enrolled.

Receiving a bill. In most cases, your provider will ask you to make a payment toward your Cost Sharing at the time you receive Services. Keep in mind that this payment may cover only a portion of the total Cost Sharing for the covered Services you receive, and you will be billed for any additional Cost Sharing amounts that are due. In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for any Cost Sharing amounts that are due. For example, some Laboratory Departments do not collect Cost Sharing, and you will be billed for any Cost Sharing amounts that are due.

The following are examples of when you may get a bill:

- You receive Services during your visit that were not scheduled when you made your payment at check-in. For example, if you are scheduled to receive treatment for an existing condition, at check-in you will be asked to pay the Cost Sharing that applies to these Services. If during your visit your provider finds another problem with your health, your provider may perform or order additional unscheduled Services to diagnose your problem. You will be billed for any Cost Sharing that applies for each of these additional unscheduled Services, in addition to the Cost Sharing amount you paid at check-in for the treatment of your existing condition
- You receive Services from a second provider during your visit that were not scheduled when you made your payment at check-in. For example, if you are scheduled to receive a diagnostic exam, at check-in you will be asked to pay the Cost Sharing that applies to these Services. If during your diagnostic exam your provider confirms a problem with your health, your provider may request the assistance of another provider to perform additional unscheduled Services (such as an outpatient procedure). You will be billed for any Cost Sharing that applies for the unscheduled Services of the second provider, in addition to the Cost Sharing amount you paid at check-in for your diagnostic exam
- You go in for Preventive Care Services and receive non-preventive Services during your visit that were not scheduled when you made your payment at check-in. For example, if you go in for a routine physical maintenance exam, at check-in you will be asked to pay the Cost Sharing that applies to these Services (the Cost Sharing may be "no charge"). If during your routine physical maintenance exam your provider finds a problem with your health, your provider may order non-preventive Services to diagnose your problem (such as laboratory tests). You will be billed for any Cost Sharing that applies for the non-preventive Services performed to diagnose your problem, in addition to the Cost Sharing amount you paid at check-in for your routine physical maintenance exam
- At check-in, you ask to be billed for some or all of the Cost Sharing for the Services you will receive, and the provider agrees to bill you
- Medical Group authorizes a referral to a Non–Plan Provider and the provider does not collect Cost Sharing at the time you receive Services

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

Sharing for the procedure, along with any past-due infertility-related Cost Sharing, before you can schedule an infertility procedure.

For more information about Cost Sharing. If you have questions about Cost Sharing for specific Services that you are scheduled to receive or that your provider orders during a visit or procedure, please visit our website at **kp.org/memberestimates** to use our Cost Sharing estimate tool or call our Member Service Contact Center weekdays 7 a.m. to 5 p.m. toll free at 1-800-390-3507 (TTY users call 1-800-777-1370).

Noncovered Services. If you receive Services that are not covered under this *Evidence of Coverage*, you may be liable for the full price of those Services. Payments you make for noncovered Services are not Cost Sharing.

Deductibles

In any calendar year, you must pay Charges for Services subject to the Deductible until you meet one of the following Deductible amounts:

- **$500** per calendar year for self-only enrollment (a Family of one Member)
- **$500** per calendar year for any one Member in a Family of two or more Members
- **$1,000** per calendar year for an entire Family of two or more Members

If you are a Member in a Family of two or more Members, you reach the Deductible either when you meet the amount for any one Member, or when your entire Family reaches the Family amount. For example, suppose you have reached the **$500** Deductible. For Services subject to the Deductible, you will not pay Charges during rest of the calendar year, but every other Member in your Family must continue to pay Charges during the calendar year until the entire Family reaches the **$1,000** Deductible.

After you meet the Deductible and for the remainder of the calendar year, you pay the applicable Copayment or Coinsurance subject to the limits described under "Annual out-of-pocket maximum" in this "Benefits and Cost Sharing" section.

Services that are subject to the Deductible. The Cost Sharing that you must pay for covered Services is in this "Benefits and Cost Sharing" section. When the Cost Sharing is described as "subject to the Deductible," and you have not met the Deductible, you must pay Charges for those Services. Note: When we cover Services at "no charge" subject to the Deductible and you have not met your Deductible, you must pay Charges for the Services.

If you would like an estimate of the Charges for a Service before you schedule an appointment or procedure, please visit our website at **kp.org/memberestimates** to use our Cost Sharing estimate tool or call our Member Service Contact Center weekdays 7 a.m. to 5 p.m. toll free at 1-800-390-3507 (TTY users call 1-800-777-1370). Note: If you pay a Deductible amount for a Service that has a visit limit, the Services count toward reaching the limit.

After you receive the Services, we will send you a bill that lists Charges for the Services you received, payments and credits applied to your account, and any amounts you still owe. You may receive more than one bill for a single outpatient visit or hospital stay. For example, you may receive a bill for physician services and a separate bill for hospital services. In addition, it may take more than one bill to reflect all of the Services you received. If we determine that you overpaid and are due a refund, then we will send a refund to you within 4 weeks after we make that determination.

Keeping track of the Deductible. When you pay an amount toward your Deductible, we will give you a receipt and we will send you a Summary of Accumulation. The Summary of Accumulation will include the total amount you have paid toward your Deductible and toward your annual out-of-pocket maximum. You can also obtain a copy of this Summary of Accumulation from our Member Service Contact Center weekdays 7 a.m. to 5 p.m. toll free at 1-800-390-3507 (TTY users call 1-800-777-1370). Any overpayments will be refunded to you.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service (after you meet any applicable Deductible) is described in this "Benefits and Cost Sharing" section.

Annual out-of-pocket maximum

There is a limit to the total amount of Cost Sharing you must pay under this *Evidence of Coverage* in a calendar year for all of the covered Services listed below that you receive in the same calendar year. The limit is one of the following amounts:

- **$3,000** per calendar year for self-only enrollment (a Family of one Member)
- **$3,000** per calendar year for any one Member in a Family of two or more Members
- **$6,000** per calendar year for an entire Family of two or more Members

If you are a Member in a Family of two or more Members, you reach the annual out-of-pocket maximum either when you meet the maximum for any one Member, or when your Family reaches the Family maximum. For example, suppose you have reached the **$3,000** maximum. For Services subject to the maximum, you will not pay any more Cost Sharing during the rest of the calendar year, but every other Member in your Family must continue to pay Cost Sharing during the calendar year until your Family reaches the **$6,000** maximum.

Payments that count toward the maximum. Any amounts you pay for covered Services subject to the Deductible, as described under "Deductibles," apply toward the annual out-of-pocket maximum. Also, the Copayments and Coinsurance you pay for the following Services apply toward the annual out-of-pocket maximum:

- Administered drugs
- Ambulance Services
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)
- Behavioral health treatment for pervasive developmental disorder or autism
- Diabetic testing supplies and equipment and insulin-administration devices
- Emergency Department visits
- Home health care
- Hospice care
- Hospital care
- Imaging, laboratory, and special procedures
- Intensive psychiatric treatment programs
- Outpatient surgery
- Prosthetic and orthotic devices
- Services performed during an office visit (including professional Services such as dialysis treatment, health education counseling and programs, and physical, occupational, and speech therapy)
- Skilled Nursing Facility care
- Transitional residential recovery Services for chemical dependency

Copayments and Coinsurance you pay for Services that are not listed above do not apply to the annual out-of-pocket maximum. For these Services, you must pay Copayments or Coinsurance even if you have already reached your annual out-of-pocket maximum.

Keeping track of the maximum. When you pay Cost Sharing that applies toward the annual out-of-pocket maximum, we will give you a receipt and we will send you a Summary of Accumulation. The Summary of Accumulation will include the total amounts you have paid toward your Deductible and toward your annual out-of-pocket maximum. You can also obtain a copy of this Summary of Accumulation from our Member Service Contact Center weekdays 7 a.m. to 5 p.m. toll free at 1-800-390-3507 (TTY users call 1-800-777-1370).

Preventive Care Services

We cover a variety of Preventive Care Services. This "Preventive Care Services" section explains Cost Sharing for some Preventive Care Services, but it does not otherwise explain coverage. For coverage of Preventive Care Services, please refer to the applicable benefit heading in this "Benefits and Cost Sharing" section, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. For example, for coverage of outpatient imaging Services, please refer to the "Outpatient Imaging, Laboratory, and Special Procedures" section, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.

We cover at **no charge (not subject to the Deductible)** the Preventive Care Services on the health care reform preventive care Services list for Members enrolled in our California Regions. This list is subject to change at any time and is available on the preventive care page on our website at **kp.org/prevention** or by calling our Member Service Contact Center. Note: If you receive any other covered Services during a visit that includes Preventive Care Services on the list, you will pay the applicable Cost Sharing for those other Services.

The following are examples of Preventive Care Services that are included in our health care reform preventive care Services list:

- Routine physical maintenance exams, including well-woman exams (refer to "Outpatient Care")
- Scheduled routine prenatal exams (refer to "Outpatient Care")
- Well-child exams for children 0-23 months (refer to "Outpatient Care")
- Health education counseling programs (refer to "Health Education")
- Immunizations (refer to "Outpatient Care")

- Routine preventive imaging and laboratory Services (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

Outpatient Care

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

- Primary and specialty care consultations, exams, and treatment (other than those described below in this "Outpatient Care" section): **10% Coinsurance subject to the Deductible**
- Preventive Care Services:
  - routine physical maintenance exams, including well-woman exams: **no charge (not subject to the Deductible)**
  - screening and counseling Services, such as obesity counseling, routine vision and hearing screenings, health education, and depression screening: **no charge (not subject to the Deductible)**
  - well-child preventive exams for Members through age 23 months: **no charge (not subject to the Deductible)**
  - after confirmation of pregnancy, the normal series of regularly scheduled preventive prenatal care exams and the first postpartum follow-up consultation and exam: **no charge (not subject to the Deductible)**
  - comprehensive breastfeeding support and counseling: **no charge (not subject to the Deductible)**
  - alcohol and substance abuse screenings: **no charge (not subject to the Deductible)**
  - developmental screenings to diagnose and assess potential developmental delays: **no charge (not subject to the Deductible)**
  - immunizations (including the vaccine) administered to you in a Plan Medical Office: **no charge (not subject to the Deductible)**
  - flexible sigmoidoscopies: **no charge (not subject to the Deductible)**
  - screening colonoscopies: **no charge (not subject to the Deductible)**
- Allergy injections (including allergy serum): **10% Coinsurance subject to the Deductible**
- Outpatient surgery and other outpatient procedures: **10% Coinsurance subject to the Deductible**
- Physical, occupational, and speech therapy: **10% Coinsurance subject to the Deductible**
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program: **10% Coinsurance subject to the Deductible**
- Urgent Care consultations, exams, and treatment: **10% Coinsurance subject to the Deductible**
- Emergency Department visits: **a $100 Copayment per visit (not subject to the Deductible)**. The Emergency Department Copayment does not apply if you are admitted directly to the hospital as an inpatient for covered Services, or if you are admitted for observation and are then admitted directly to the hospital as an inpatient for covered Services (for inpatient care, please refer to "Hospital Inpatient Care" in this "Benefits and Cost Sharing" section). However, the Emergency Department Copayment does apply if you are admitted for observation but are not admitted as an inpatient
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician: **no charge subject to the Deductible**
- Acupuncture Services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain): **10% Coinsurance subject to the Deductible**
- Blood, blood products, and their administration: **no charge subject to the Deductible**
- Administered drugs (drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials) prescribed in accord with our drug formulary guidelines, if administration or observation by medical personnel is required and they are administered to you in a Plan Medical Office or during home visits: **no charge subject to the Deductible** except that tuberculosis tests are **not subject to the Deductible**
- Some types of outpatient consultations, exams, and treatment may be available as group appointments, which we cover at **10% Coinsurance subject to the Deductible**

Services not covered under this "Outpatient Care" section

The following types of outpatient Services are covered only as described under these headings in this "Benefits and Cost Sharing" section:

- Bariatric Surgery
- Behavioral Health Treatment for Pervasive Developmental Disorder or Autism

- Chemical Dependency Services
- Dental and Orthodontic Services
- Dialysis Care
- Durable Medical Equipment for Home Use
- Family Planning Services
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Infertility Services
- Mental Health Services
- Ostomy and Urological Supplies
- Outpatient Imaging, Laboratory, and Special Procedures
- Outpatient Prescription Drugs, Supplies, and Supplements
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Transplant Services
- Vision Services

Hospital Inpatient Care

We cover the following inpatient Services at **10% Coinsurance subject to the Deductible** in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals inside our Service Area:

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

Services not covered under this "Hospital Inpatient Care" section

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

- Bariatric Surgery
- Chemical Dependency Services
- Dental and Orthodontic Services
- Dialysis Care
- Hospice Care
- Infertility Services
- Mental Health Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Skilled Nursing Facility Care
- Transplant Services

Ambulance Services

Emergency

We cover at **10% Coinsurance subject to the Deductible** Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

- A reasonable person would have believed that the medical condition was an Emergency Medical Condition which required ambulance Services

- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

If you receive emergency ambulance Services that are not ordered by a Plan Provider, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us. Please refer to the "Post-Service Claims and Appeals" section for how to file a claim for reimbursement.

Nonemergency

Inside our Service Area, we cover nonemergency ambulance and psychiatric transport van Services at **10% Coinsurance subject to the Deductible** if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to or from covered Services.

Ambulance Services exclusion

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

Bariatric Surgery

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

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

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

If you live 50 miles or more from the facility to which you are referred for a covered bariatric surgery, we will reimburse you for certain travel and lodging expenses **(not subject to the Deductible)** if you receive prior written authorization from the Medical Group and send us adequate documentation including receipts. We will not, however, reimburse you for any travel or lodging expenses if you were offered a referral to a facility that is less than 50 miles from your home. We will reimburse authorized and documented travel and lodging expenses as follows:

- Transportation for you to and from the facility up to $130 per round trip for a maximum of three trips (one pre-surgical visit, the surgery, and one follow-up visit), including any trips for which we provided reimbursement under any other evidence of coverage offered by your Group **(not subject to the Deductible)**
- Transportation for one companion to and from the facility up to $130 per round trip for a maximum of two trips (the surgery and one follow-up visit), including any trips for which we provided reimbursement under any other evidence of coverage offered by your Group **(not subject to the Deductible)**
- One hotel room, double-occupancy, for you and one companion not to exceed $100 per day for the pre-surgical visit and the follow-up visit, up to two days per trip, including any hotel accommodations for which we provided reimbursement under any other evidence of coverage offered by your Group **(not subject to the Deductible)**
- Hotel accommodations for one companion not to exceed $100 per day for the duration of your surgery stay, up to four days, including any hotel accommodations for which we provided reimbursement under any other evidence of coverage offered by your Group **(not subject to the Deductible)**

Services not covered under this "Bariatric Surgery" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Behavioral Health Treatment for Pervasive Developmental Disorder or Autism

The following terms have special meaning when capitalized and used in this "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" section:

- "Qualified Autism Service Provider" means a provider who has the experience and competence to design, supervise, provide, or administer treatment for pervasive developmental disorder or autism and is either of the following:
  - a person, entity, or group that is certified by a national entity (such as the Behavior Analyst Certification Board) that is accredited by the National Commission for Certifying Agencies
  - a person licensed in California as a physician, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist
- "Qualified Autism Service Professional" means a person who meets all of the following criteria:
  - provides behavioral health treatment
  - is employed and supervised by a Qualified Autism Service Provider
  - provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
  - is a behavioral health treatment provider approved as a vendor by a California regional center to provide Services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations
  - has training and experience in providing Services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code
- "Qualified Autism Service Paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:
  - is employed and supervised by a Qualified Autism Service Provider
  - provides treatment and implements Services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
  - meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code
  - has adequate education, training, and experience, as certified by a Qualified Autism Service Provider

We cover behavioral health treatment for pervasive developmental disorder or autism (including applied behavior analysis and evidence-based behavior intervention programs) that develops or restores, to the maximum extent practicable, the functioning of a person with pervasive developmental disorder or autism and that meet all of the following criteria:

- The treatment is prescribed by a Plan Physician, or is developed by a Plan Provider who is a psychologist
- The treatment is provided under a treatment plan prescribed by a Plan Provider who is a Qualified Autism Service Provider
- The treatment is administered by a Plan Provider who is one of the following:
  - a Qualified Autism Service Provider
  - a Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider
  - a Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service Provider
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the Member being treated
- The treatment plan is reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate
- The treatment plan requires the Qualified Autism Service Provider to do all of the following:
  - Describe the Member's behavioral health impairments to be treated
  - Design an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member's progress is evaluated and reported
  - Provide intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism

- Discontinue intensive behavioral intervention Services when the treatment goals and objectives are achieved or no longer appropriate

- The treatment plan is not used for either of the following:
  - for purposes of providing (or for the reimbursement of) respite care, day care, or educational services
  - to reimburse a parent for participating in the treatment program

You pay the following for these covered Services:

- Individual visits: **10% Coinsurance subject to the Deductible**
- Group visits: **10% Coinsurance subject to the Deductible**

Effective as of the date that federal proposed final rulemaking for essential health benefits is issued, we will cover Services under this "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" section only if they are included in the essential health benefits that all health plans will be required by federal regulations to provide under section 1302(b) of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act.

Chemical Dependency Services

Inpatient detoxification

We cover hospitalization at **10% Coinsurance subject to the Deductible** in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Outpatient chemical dependency care

We cover the following Services for treatment of chemical dependency:

- Day-treatment programs
- Intensive outpatient programs
- Individual and group chemical dependency counseling
- Medical treatment for withdrawal symptoms

You pay the following for these covered Services:

- Individual chemical dependency evaluation and treatment: **10% Coinsurance subject to the Deductible**
- Group chemical dependency treatment: **10% Coinsurance subject to the Deductible**

We cover methadone maintenance treatment at **no charge subject to the Deductible** for pregnant Members during pregnancy and for two months after delivery at a licensed treatment center approved by the Medical Group. We do not cover methadone maintenance treatment in any other circumstances.

Transitional residential recovery Services

We cover chemical dependency treatment in a nonmedical transitional residential recovery setting approved in writing by the Medical Group. We cover these Services at **10% Coinsurance (not subject to the Deductible)**. These settings provide counseling and support services in a structured environment.

Services not covered under this "Chemical Dependency Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Outpatient self-administered drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

Chemical dependency Services exclusion

- Services in a specialized facility for alcoholism, drug abuse, or drug addiction except as otherwise described in this "Chemical Dependency Services" section

Dental and Orthodontic Services

We do not cover most dental and orthodontic Services, but we do cover some dental and orthodontic Services as described in this "Dental and Orthodontic Services" section.

Dental Services for radiation treatment

We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist (as described in "Medical Group authorization procedure for certain

referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental anesthesia

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

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

We do not cover any other Services related to the dental procedure, such as the dentist's Services.

Dental and orthodontic Services for cleft palate

We cover dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic Services, if they meet all of the following requirements:

- The Services are an integral part of a reconstructive surgery for cleft palate that we are covering under "Reconstructive Surgery" in this "Benefits and Cost Sharing" section
- A Plan Provider provides the Services or the Medical Group authorizes a referral to a Non–Plan Provider who is a dentist or orthodontist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)

Cost Sharing for dental and orthodontic Services

You pay the following for dental and orthodontic Services covered under this "Dental and Orthodontic Services" section:

- Hospital inpatient care: **10% Coinsurance subject to the Deductible**
- Outpatient consultations, exams, and treatment: **10% Coinsurance subject to the Deductible**
- Outpatient surgery and other outpatient procedures: **10% Coinsurance subject to the Deductible**

Services not covered under this "Dental and Orthodontic Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Outpatient imaging, laboratory, and special procedures (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient administered drugs (refer to "Outpatient Care"), except that we cover outpatient administered drugs under "Dental anesthesia" in this "Dental and Orthodontic Services" section
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Dialysis Care

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

- The Services are provided inside our Service Area
- You satisfy all medical criteria developed by the Medical Group and by the facility providing the dialysis
- A Plan Physician provides a written referral for care at the facility

After you receive appropriate training at a dialysis facility we designate, we also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside our Service Area at **no charge subject to the Deductible**. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

You pay the following for these covered Services related to dialysis:

- Inpatient dialysis care: **10% Coinsurance subject to the Deductible**
- One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, exam, or treatment: **no charge subject to the Deductible**
- Hemodialysis treatment at a Plan Facility: **10% Coinsurance subject to the Deductible**

- All other outpatient consultations, exams, and treatment: **10% Coinsurance subject to the Deductible**

Services not covered under this "Dialysis Care" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Durable medical equipment for home use (refer to "Durable Medical Equipment for Home Use")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Dialysis Care exclusions

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

Durable Medical Equipment for Home Use

Inside our Service Area, we cover durable medical equipment for use in your home (or another location used as your home) in accord with our durable medical equipment formulary guidelines. Durable medical equipment for home use is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.

Durable medical equipment for diabetes

The following diabetes blood-testing supplies and equipment and insulin-administration devices are covered under this "Durable Medical Equipment for Home Use" section:

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

Cost Sharing for durable medical equipment

You pay the following for covered durable medical equipment (including repair or replacement of covered equipment):

- External sexual dysfunction devices: **10% Coinsurance (not subject to the Deductible)**
- Breast pumps and supplies: Refer to "Breastfeeding supplies" in this "Durable Medical Equipment" section
- All other covered durable medical equipment: **10% Coinsurance (not subject to the Deductible)**

Outside the Service Area

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

- Standard curved handle cane
- Standard crutches
- For diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices) from a Plan Pharmacy
- Insulin pumps and supplies to operate the pump (but not including insulin or any other drugs), after completion of training and education on the use of the pump
- Nebulizers and their supplies for the treatment of pediatric asthma
- Peak flow meters from a Plan Pharmacy

About our durable medical equipment formulary

Our durable medical equipment formulary includes the list of durable medical equipment that has been approved by our Durable Medical Equipment Formulary Executive Committee for our Members. Our durable medical equipment formulary was developed by a multidisciplinary clinical and operational work group with review and input from Plan Physicians and medical professionals with durable medical equipment expertise (for example: physical, respiratory, and enterostomal therapists and home health). A multidisciplinary Durable Medical Equipment Formulary Executive Committee is responsible for reviewing and revising the durable medical equipment formulary. Our durable medical equipment formulary is periodically updated to keep pace with changes in medical technology and clinical

practice. To find out whether a particular item is included in our durable medical equipment formulary, please call our Member Service Contact Center.

Our formulary guidelines allow you to obtain nonformulary durable medical equipment (equipment not listed on our durable medical equipment formulary for your condition) if the equipment would otherwise be covered and the Medical Group determines that it is Medically Necessary as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

Breastfeeding supplies

We will cover at **no charge (not subject to the Deductible)** one retail-grade breast pump per pregnancy and the necessary supplies to operate it, such as one set of bottles. We will decide whether to rent or purchase the item and we choose the vendor. We cover this pump for convenience purposes. The pump is not subject to prior authorization requirements or the formulary guidelines.

Inside our Service Area, if you or your baby has a medical condition that requires the use of a breast pump, we will cover at **no charge (not subject to the Deductible)** a hospital-grade breast pump and the necessary supplies to operate it, in accord with our durable medical equipment formulary guidelines. We will determine whether to rent or purchase the equipment and we choose the vendor. Hospital-grade breast pumps on our formulary are subject to the durable medical equipment prior authorization requirements as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section. For more information about our durable medical equipment formulary, see the "About our durable medical equipment formulary" in this "Durable Medical Equipment for Home Use" section.

Services not covered under this "Durable Medical Equipment for Home Use" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Durable medical equipment for home use exclusions

- Comfort, convenience, or luxury equipment or features except for retail-grade breast pumps as described under "Breastfeeding supplies" in this "Durable Medical Equipment for Home Use" section
- Exercise or hygiene equipment
- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies)
- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to loss or misuse

Family Planning Services

We cover the following family planning Services subject to the Cost Sharing indicated:

- Family planning counseling: **no charge (not subject to the Deductible)**
- Consultations for internally implanted time-release contraceptives or intrauterine devices (IUDs): **no charge (not subject to the Deductible)**
- Female sterilization procedures: **no charge (not subject to the Deductible)**
- Male sterilization procedures: **10% Coinsurance subject to the Deductible**
- Medically Necessary termination of pregnancy: **10% Coinsurance subject to the Deductible**
- Voluntary termination of pregnancy: **10% Coinsurance subject to the Deductible**

Services not covered under this "Family Planning Services" section

- Outpatient laboratory and imaging services associated with family planning services (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient contraceptive drugs and devices (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Family Planning Services exclusions

- Reversal of voluntary sterilization

Health Education

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

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

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

You pay the following for these covered Services:

- Covered health education programs, which may include programs provided online and counseling over the phone: **no charge (not subject to the Deductible)**
- Individual counseling when the office visit is solely for health education: **no charge (not subject to the Deductible)**
- Health education provided during an outpatient consultation or exam covered in another part of this "Benefits and Cost Sharing" section: **no additional Cost Sharing beyond the Cost Sharing required in that other part of this "Benefits and Cost Sharing" section**
- Covered health education materials: **no charge (not subject to the Deductible)**

Hearing Services

We do not cover hearing aids (other than internally-implanted devices as described in the "Prosthetic and Orthotic Devices" section). However, we do cover the following:

- Routine hearing screenings that are Preventive Care Services: **no charge (not subject to the Deductible)**
- Hearing exams to determine the need for hearing correction: **no charge (not subject to the Deductible)**

Services not covered under this "Hearing Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Hearing Services exclusions

- Hearing aids and tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. We cover home health care at **10% Coinsurance (not subject to the Deductible)** only if all of the following are true:

- You are substantially confined to your home (or a friend's or relative's home)
- Your condition requires the Services of a nurse, physical therapist, occupational therapist, or speech therapist (home health aide Services are not covered unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide)
- A Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home
- The Services are provided inside our Service Area

We cover only part-time or intermittent home health care, as follows:

- Up to two hours per visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to four hours per visit for visits by a home health aide
- Up to three visits per day (counting all home health visits)
- Up to 100 visits per calendar year (counting all home health visits)

Note: If a visit by a nurse, medical social worker, or physical, occupational, or speech therapist lasts longer than two hours, then each additional increment of two hours counts as a separate visit. If a visit by a home health aide lasts longer than four hours, then each additional increment of four hours counts as a separate visit. For example, if a nurse comes to your home for three hours and then leaves, that counts as two visits. Also, each person providing Services counts toward these visit limits. For example, if a home health aide and a nurse are both at your home during the same two hours, that counts as two visits.

Services not covered under this "Home Health Care" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Behavioral health treatment for pervasive developmental disorder or autism (refer to "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism")
- Dialysis care (refer to "Dialysis Care")
- Durable medical equipment (refer to "Durable Medical Equipment for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Home health care exclusions

- Care of a type that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. This care is excluded even if we would cover the care if it were provided by a qualified medical professional in a hospital or a Skilled Nursing Facility
- Care in the home if the home is not a safe and effective treatment setting

Hospice Care

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

We cover the hospice Services listed below at **10% Coinsurance (not subject to the Deductible)** only if all of the following requirements are met:

- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside our Service Area or inside California but within 15 miles or 30 minutes from our Service Area (including a friend's or relative's home even if you live there temporarily)
- The Services are provided by a licensed hospice agency that is a Plan Provider
- The Services are necessary for the palliation and management of your terminal illness and related conditions

If all of the above requirements are met, we cover the following hospice Services, which are available on a 24-hour basis if necessary for your hospice care:

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

- Counseling and bereavement services
- Dietary counseling
- The following care during periods of crisis when you need continuous care to achieve palliation or management of acute medical symptoms:
  - nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
  - short-term inpatient care required at a level that cannot be provided at home

Infertility Services

We cover the following Services related to involuntary infertility at **50% Coinsurance subject to the Deductible**:

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

Services not covered under this "Infertility Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Infertility Services exclusions

- Services to reverse voluntary, surgically induced infertility
- Semen and eggs (and Services related to their procurement and storage)

Mental Health Services

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

"Mental Disorders" include the following conditions:

- Severe Mental Illness of a person of any age. "Severe Mental Illness" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa
- A Serious Emotional Disturbance of a child under age 18. A "Serious Emotional Disturbance" of a child under age 18 means a condition identified as a "mental disorder" in the *DSM*, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:
  - as a result of the mental disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
  - the child displays psychotic features, or risk of suicide or violence due to a mental disorder
  - the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

Outpatient mental health Services

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

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

You pay the following for these covered Services:

- Individual mental health evaluation and treatment: **10% Coinsurance subject to the Deductible**
- Group mental health treatment: **10% Coinsurance subject to the Deductible**

Note: Outpatient intensive psychiatric treatment programs are not covered under this "Outpatient mental health Services" section (refer to "Intensive psychiatric treatment programs" under "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in this "Mental Health Services" section).

Inpatient psychiatric hospitalization and intensive psychiatric treatment programs

Inpatient psychiatric hospitalization. We cover inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and Services of Plan Physicians and other Plan Providers who are licensed health care professionals acting within the scope of their license. We cover these Services at **10% Coinsurance subject to the Deductible**.

Intensive psychiatric treatment programs. We cover at **10% Coinsurance subject to the Deductible** the following intensive psychiatric treatment programs at a Plan Facility:

- Short-term hospital-based intensive outpatient care (partial hospitalization)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis
- Psychiatric observation for an acute psychiatric crisis

Services not covered under this "Mental Health Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

Ostomy and Urological Supplies

Inside our Service Area, we cover ostomy and urological supplies prescribed in accord with our soft goods formulary guidelines at **no charge (not subject to the Deductible)**. We select the vendor, and coverage is limited to the standard supply that adequately meets your medical needs.

About our soft goods formulary

Our soft goods formulary includes the list of ostomy and urological supplies that have been approved by our Soft Goods Formulary Executive Committee for our Members. Our Soft Goods Formulary Executive Committee is responsible for reviewing and revising the soft goods formulary. Our soft goods formulary is periodically updated to keep pace with changes in medical technology and clinical practice. To find out whether a particular ostomy or urological supply is included in our soft goods formulary, please call our Member Service Contact Center.

Our formulary guidelines allow you to obtain nonformulary ostomy and urological supplies (those not listed on our soft goods formulary for your condition) if they would otherwise be covered and the Medical Group determines that they are Medically Necessary as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

Ostomy and urological supplies exclusion

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Special Procedures

We cover the following Services at the Cost Sharing indicated only when prescribed as part of care covered under other headings in this "Benefits and Cost Sharing" section:

- Imaging Services that are Preventive Care Services:
  - preventive mammograms: **no charge (not subject to the Deductible)**
  - preventive aortic aneurysm screenings: **no charge (not subject to the Deductible)**
  - bone density CT scans: **no charge (not subject to the Deductible)**
  - bone density DEXA scans: **no charge (not subject to the Deductible)**
- All other CT scans, and all MRIs and PET scans: **10% Coinsurance subject to the Deductible**

- All other imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds: **10% Coinsurance subject to the Deductible**
- Nuclear medicine: **10% Coinsurance subject to the Deductible**
- Laboratory tests:
  - laboratory tests to monitor the effectiveness of dialysis: **no charge subject to the Deductible**
  - fecal occult blood tests: **no charge (not subject to the Deductible)**
  - routine laboratory tests and screenings that are Preventive Care Services, such as cervical cancer screenings, prostate specific antigen tests, cholesterol tests (lipid panel and profile), fasting blood glucose tests, glucose tolerance tests, certain sexually transmitted disease (STD) tests, and HIV tests: **no charge (not subject to the Deductible)**
  - all other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available): **10% Coinsurance subject to the Deductible**
- Routine preventive retinal photography screenings: **no charge (not subject to the Deductible)**
- All other diagnostic procedures provided by Plan Providers who are not physicians (such as EKGs and EEGs): **10% Coinsurance subject to the Deductible**
- Radiation therapy: **no charge subject to the Deductible**
- Ultraviolet light treatments: **no charge (not subject to the Deductible)**

Services not covered under this "Outpatient Imaging, Laboratory, and Special Procedures" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Services related to diagnosis and treatment of infertility (refer to "Infertility Services")

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section when prescribed as follows and obtained at a Plan Pharmacy or through our mail-order service:

- Items prescribed by Plan Physicians in accord with our drug formulary guidelines
- Items prescribed by the following Non–Plan Providers unless a Plan Physician determines that the item is not Medically Necessary or the drug is for a sexual dysfunction disorder:
  - Dentists if the drug is for dental care
  - Non–Plan Physicians if the Medical Group authorizes a written referral to the Non–Plan Physician (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section) and the drug, supply, or supplement is covered as part of that referral
  - Non–Plan Physicians if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described under "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)

How to obtain covered items

You must obtain covered drugs, supplies, and supplements at a Plan Pharmacy or through our mail-order service unless the item is obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section.

Please refer to *Your Guidebook* for the locations of Plan Pharmacies in your area.

Refills. You may be able to order refills at a Plan Pharmacy, through our mail-order service, or through our website at **kp.org/rxrefill**. A Plan Pharmacy or *Your Guidebook* can give you more information about obtaining refills, including the options available to you for obtaining refills. For example, a few Plan Pharmacies don't dispense refills and not all drugs can be mailed through our mail-order service. Please check with a Plan Pharmacy if you have a question about whether or not your prescription can be mailed or obtained at a Plan Pharmacy. Items available through our mail-order service are subject to change at any time without notice.

Outpatient contraceptive drugs and devices

We cover the following contraceptive drugs and devices:

- Oral contraceptives (including emergency contraception pills)
- Contraceptive rings
- Contraceptive patches

- Diaphragms
- Cervical caps

Cost Sharing for outpatient contraceptive drugs and items. The Cost Sharing for these items is as follows:

- Diaphragms and cervical caps: **no charge (not subject to the Deductible)**
- Generic contraceptive rings, contraceptive patches, and oral contraceptives (other than emergency contraceptive pills): **no charge (not subject to the Deductible)** for up to a 100-day supply
- Brand-name contraceptive rings, contraceptive patches, and oral contraceptives (other than emergency contraceptive pills): **no charge (not subject to the Deductible)** for up to a 100-day supply
- Emergency contraceptive pills: **no charge (not subject to the Deductible)**

All other outpatient drugs, supplies, and supplements

We cover the following outpatient drugs, supplies, and supplements:

- Drugs for which a prescription is required by law. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary
- Disposable needles and syringes needed for injecting covered drugs and supplements
- Inhaler spacers needed to inhale covered drugs

Cost Sharing for outpatient drugs, supplies, and supplements. The Cost Sharing for these items is as follows:

- Generic items (other than those described below in this "Cost Sharing for outpatient drugs, supplies, and supplements" section) at a Plan Pharmacy: **a $10 Copayment** for up to a 30-day supply, **a $20 Copayment** for a 31- to 60-day supply, or **a $30 Copayment** for a 61- to 100-day supply
- Generic items (other than those described below in this "Cost Sharing for outpatient drugs, supplies, and supplements" section) through our mail-order service: **a $10 Copayment** for up to a 30-day supply or **a $20 Copayment** for a 31- to 100-day supply
- Brand-name items and compounded products (other than those described below in this "Cost Sharing for outpatient drugs, supplies, and supplements" section) at a Plan Pharmacy: **a $20 Copayment** for up to a 30-day supply, **a $40 Copayment** for a 31- to 60-day supply, or **a $60 Copayment** for a 61- to 100-day supply
- Brand-name items and compounded products (other than those described below in this "Cost Sharing for outpatient drugs, supplies, and supplements" section) through our mail-order service: **a $20 Copayment** for up to a 30-day supply or **a $40 Copayment** for a 31- to 100-day supply
- Drugs prescribed for the treatment of sexual dysfunction disorders: **50% Coinsurance** for up to a 100-day supply
- Drugs prescribed for the treatment of infertility: **50% Coinsurance** for up to a 100-day supply
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria) and elemental dietary enteral formula when used as a primary therapy for regional enteritis: **no charge** for up to a 30-day supply
- Hematopoietic agents for dialysis: **no charge** for up to a 30-day supply
- Continuity drugs (if this *Evidence of Coverage* is amended to exclude a drug that we have been covering and providing to you under this *Evidence of Coverage*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration): **50% Coinsurance** for up to a 30-day supply in a 30-day period

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

Certain intravenous drugs, supplies, and supplements

We cover certain self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as an intravenous or intraspinal-infusion) at **no charge** for up to a 30-day supply and the supplies and equipment required for their administration at **no charge**. Note: Injectable drugs, insulin, and drugs for the diagnosis and treatment of infertility are not covered under this paragraph (instead, refer to the "Outpatient drugs, supplies, and supplements" paragraph).

Diabetes urine-testing supplies and insulin-administration devices

We cover ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing at **no charge** for up to a 100-day supply.

We cover the following insulin-administration devices at **a $10 Copayment** for up to a 100-day supply: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear).

Day supply limit

The prescribing physician or dentist determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, Plan Physicians determine the amount of an item that constitutes a Medically Necessary 30-, 60-, or 100-day supply for you. Upon payment of the Cost Sharing specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, you will receive the supply prescribed up to the day supply limit also specified in this section. The day supply limit is either a 30-day supply in a 30-day period or a 100-day supply in a 100-day period. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantities that exceed the day supply limit. Note: We cover episodic drugs prescribed for the treatment of sexual dysfunction disorders up to a maximum of 8 doses in any 30-day period or up to 27 doses in any 100-day period.

The pharmacy may reduce the day supply dispensed at the Cost Sharing specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan Pharmacy can tell you if a drug you take is one of these drugs).

About our drug formulary

Our drug formulary includes the list of drugs that have been approved by our Pharmacy and Therapeutics Committee for our Members. Our Pharmacy and Therapeutics Committee, which is primarily composed of Plan Physicians, selects drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature. The Pharmacy and Therapeutics Committee meets quarterly to consider additions and deletions based on new information or drugs that become available. If you would like to request a copy of our drug formulary, please call our Member Service Contact Center. Note: The presence of a drug on our drug formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition.

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

Services not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "Durable Medical Equipment for Home Use")
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care")
- Drugs prescribed for pain control and symptom management of the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Durable medical equipment used to administer drugs (refer to "Durable Medical Equipment for Home Use")
- Outpatient administered drugs (refer to "Outpatient Care")

Outpatient prescription drugs, supplies, and supplements exclusions

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging
- Compounded products unless the drug is listed on our drug formulary or one of the ingredients requires a prescription by law
- Drugs prescribed to shorten the duration of the common cold

Prosthetic and Orthotic Devices

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

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes

- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select

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

Internally implanted devices

We cover prosthetic and orthotic devices, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if they are implanted during a surgery that we are covering under another section of this "Benefits and Cost Sharing" section. We cover these devices at **no charge subject to the Deductible**.

External devices

We cover the following external prosthetic and orthotic devices at **no charge (not subject to the Deductible)**:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres required to hold a prosthesis every 12 months
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect
- Other covered prosthetic and orthotic devices:
  - prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity
  - rigid and semi-rigid orthotic devices required to support or correct a defective body part

Services not covered under this "Prosthetic and Orthotic Devices" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Contact lenses to treat aniridia or aphakia (refer to "Vision Services")

Prosthetic and orthotic devices exclusions

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Nonrigid supplies, such as elastic stockings and wigs, except as otherwise described above in this "Prosthetic and Orthotic Devices" section
- Comfort, convenience, or luxury equipment or features
- Shoes or arch supports, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications

Reconstructive Surgery

We cover the following reconstructive surgery Services:

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

You pay the following for covered reconstructive surgery Services:

- Outpatient consultations, exams, and treatment: **10% Coinsurance subject to the Deductible**
- Outpatient surgery: **10% Coinsurance subject to the Deductible**
- Hospital inpatient care (including room and board, drugs, and Plan Physician Services): **10% Coinsurance subject to the Deductible**

Services not covered under this "Reconstructive Surgery" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Dental and orthodontic Services that are an integral part of reconstructive surgery for cleft palate (refer to "Dental and Orthodontic Services")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")

Reconstructive surgery exclusions

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance
- Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance

Services Associated with Clinical Trials

We cover Services associated with cancer clinical trials if all of the following requirements are met:

- You are diagnosed with cancer
- You are accepted into a phase I, II, III, or IV clinical trial for cancer
- Your treating Plan Physician, or your treating Non–Plan Physician if the Medical Group authorizes a written referral to the Non–Plan Physician for treatment of cancer (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section), recommends participation in the clinical trial after determining that it has a meaningful potential to benefit you
- The Services would be covered under this *Evidence of Coverage* if they were not provided in connection with a clinical trial
- The clinical trial has a therapeutic intent, and its end points are not defined exclusively to test toxicity
- The clinical trial involves a drug that is exempt under federal regulations from a new drug application, or the clinical trial is approved by: one of the National Institutes of Health, the federal Food and Drug Administration (in the form of an investigational new drug application), the U.S. Department of Defense, or the U.S. Department of Veterans Affairs

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

Services associated with clinical trials exclusions

- Services that are provided solely to satisfy data collection and analysis needs and are not used in your clinical management
- Services that are customarily provided by the research sponsors free of charge to enrollees in the clinical trial

Skilled Nursing Facility Care

Inside our Service Area, we cover at **10% Coinsurance subject to the Deductible** up to 100 days per benefit period (including any days we covered under any other evidence of coverage offered by your Group) of skilled inpatient Services in a Plan Skilled Nursing Facility. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment in accord with our durable medical equipment formulary if Skilled Nursing Facilities ordinarily furnish the equipment

- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Blood, blood products, and their administration
- Medical supplies
- Physical, occupational, and speech therapy
- Behavioral health treatment for pervasive developmental disorder or autism
- Respiratory therapy

Services not covered under this "Skilled Nursing Facility Care" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Outpatient imaging, laboratory, and special procedures (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

Transplant Services

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

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

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

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

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

Services not covered under this "Transplant Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Vision Services

We do not cover eyeglasses or contact lenses (except for special contact lenses described in this "Vision Services" section). However, we do cover the following:

- Routine vision screenings that are Preventive Care Services: **no charge (not subject to the Deductible)**
- Eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses: **no charge (not subject to the Deductible)**

Special contact lenses for aniridia and aphakia. We cover the following special contact lenses at Plan Medical Offices or Plan Optical Sales Offices when prescribed by a Plan Physician or Plan Optometrist:

- Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris): **no charge (not subject to the Deductible)**. We will not cover an aniridia contact lens if we provided an allowance toward (or otherwise covered) more than one aniridia contact lens for that eye within the previous 12 months (including when we provided an allowance toward, or otherwise covered, one or more aniridia contact lenses under any other evidence of coverage offered by your Group)

- Up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) per calendar year to treat aphakia (absence of the crystalline lens of the eye) for Members through age 9: **no charge (not subject to the Deductible)**. We will not cover an aphakic contact lens if we provided an allowance toward (or otherwise covered) more than six aphakic contact lenses for that eye during the same calendar year (including when we provided an allowance toward, or otherwise covered, one or more aphakic contact lenses under any other evidence of coverage offered by your Group)

Services not covered under this "Vision Services" section

Coverage for the following Services is described under other headings in this "Benefits and Cost Sharing" section:

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

Vision Services exclusions

- Industrial frames
- Eyeglass lenses and frames
- Contact lenses, including fitting and dispensing (except for special contact lenses to treat aphakia or aniridia as described under this "Vision Services" section)
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low-vision devices

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this *Evidence of Coverage* regardless of whether the services are within the scope of a provider's license or certificate. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the "Benefits and Cost Sharing" section.

Certain exams and Services

Physical exams and other Services (1) required for obtaining or maintaining employment or participation in employee programs, (2) required for insurance or licensing, or (3) on court order or required for parole or probation. This exclusion does not apply if a Plan Physician determines that the Services are Medically Necessary.

Chiropractic Services

Chiropractic Services and the Services of a chiropractor.

Conception by artificial means

Except for artificial insemination covered under "Infertility Services" in the "Benefits and Cost Sharing" section, all other Services related to conception by artificial means, such as ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and Services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

Cosmetic Services

Services that are intended primarily to change or maintain your appearance, except that this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "Benefits and Cost Sharing" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "Benefits and Cost Sharing" section: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after a mastectomy, and prostheses to replace all or part of an external facial body part

Note: Having a mental health condition does not make cosmetic Services become reconstructive surgery

Custodial care

Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, Skilled Nursing Facility, or inpatient hospital care.

Dental and orthodontic Services

Dental and orthodontic Services such as X-rays, appliances, implants, Services provided by dentists or orthodontists, dental Services following accidental injury to teeth, and dental Services resulting from medical

treatment such as surgery on the jawbone and radiation treatment.

This exclusion does not apply to Services covered under "Dental and Orthodontic Services" in the "Benefits and Cost Sharing" section.

Disposable supplies

Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies.

This exclusion does not apply to disposable supplies covered under "Durable Medical Equipment for Home Use," "Home Health Care," "Hospice Care," "Ostomy and Urological Supplies," and "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section.

Experimental or investigational Services

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

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

This exclusion does not apply to any of the following:

- Experimental or investigational Services when an investigational application has been filed with the federal Food and Drug Administration (FDA) and the manufacturer or other source makes the Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol
- Services covered under "Services Associated with Clinical Trials" in the "Benefits and Cost Sharing" section

Please refer to the "Dispute Resolution" section for information about Independent Medical Review related to denied requests for experimental or investigational Services.

Hair loss or growth treatment

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

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Durable Medical Equipment," "Home Health Care," and "Hospice Care" in the "Benefits and Cost Sharing" section.

Items and services that are not health care items and services

For example, we do not cover:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services for the purpose of increasing academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play or swimming, except that this exclusion for "teaching play" does not apply to Services that are part of a behavioral health therapy treatment plan and covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the "Benefits and Cost Sharing" section
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy, except that this exclusion for aquatic therapy and other water therapy does not apply to therapy Services that are part of a physical therapy treatment plan and covered under "Hospital Inpatient Care," "Outpatient Care," "Home Health Care, "Hospice Services," or "Skilled Nursing Facility Care" in the "Benefits and Cost Sharing" section

Items and services to correct refractive defects of the eye

Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism.

Massage therapy

Massage therapy, except that this exclusion does not apply to therapy Services that are part of a physical therapy treatment plan and covered under "Hospital Inpatient Care," "Outpatient Care," "Home Health Care, "Hospice Services," or "Skilled Nursing Facility Care" in the "Benefits and Cost Sharing" section.

Oral nutrition

Outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas, and food.

This exclusion does not apply to any of the following:

- Amino acid–modified products and elemental dietary enteral formula covered under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section
- Enteral formula covered under "Prosthetic and Orthotic Devices" in the "Benefits and Cost Sharing" section

Residential care

Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a Skilled Nursing Facility, inpatient respite care covered in the "Hospice Care" section, a licensed facility providing crisis residential Services covered under "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in the "Mental Health Services" section, or a licensed facility providing transitional residential recovery Services covered under the "Chemical Dependency Services" section.

Routine foot care items and services

Routine foot care items and services that are not Medically Necessary.

Services not approved by the federal Food and Drug Administration

Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other Services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion applies to Services provided anywhere, even outside the U.S.

This exclusion does not apply to any of the following:

- Services covered under the "Emergency Services and Urgent Care" section that you receive outside the U.S.
- Experimental or investigational Services when an investigational application has been filed with the FDA and the manufacturer or other source makes the Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol
- Services covered under "Services Associated with Clinical Trials" in the "Benefits and Cost Sharing" section

Please refer to the "Dispute Resolution" section for information about Independent Medical Review related to denied requests for experimental or investigational Services.

Services performed by unlicensed people

Services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the Member's condition does not require that the services be provided by a licensed health care provider.

This exclusion does not apply to Services covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the "Benefits and Cost Sharing" section.

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services we would otherwise cover to treat complications of the noncovered Service. For example, if you have a noncovered cosmetic surgery, we would not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and we would cover any Services that we would otherwise cover to treat that complication.

Surrogacy

Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. A "Surrogacy Arrangement" is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Please refer to "Surrogacy arrangements" under "Reductions" in this "Exclusions, Limitations, Coordination of Benefits, and Reductions" section for information about your obligations to us in connection with a Surrogacy Arrangement, including your obligations to reimburse us for any Services we cover and to provide information

about anyone who may be financially responsible for Services the baby (or babies) receive.

Transgender surgery

Travel and lodging expenses

Travel and lodging expenses, except for the following:

- In some situations if the Medical Group refers you to a Non–Plan Provider as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines **not subject to the Deductible**. Our travel and lodging guidelines are available from our Member Service Contact Center
- Reimbursement for travel and lodging expenses provided under "Bariatric Surgery" in the "Benefits and Cost Sharing" section

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services under this *Evidence of Coverage*, such as a major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor dispute. Under these circumstances, if you have an Emergency Medical Condition, call 911 or go to the nearest hospital as described under "Emergency Services" in the "Emergency Services and Urgent Care" section, and we will provide coverage and reimbursement as described in that section.

Additional limitations that apply only to a particular benefit are listed in the description of that benefit in the "Benefits and Cost Sharing" section.

Coordination of Benefits

The Services covered under this *Evidence of Coverage* are subject to coordination of benefits rules.

Coverage other than Medicare coverage

If you have medical or dental coverage under another plan that is subject to coordination of benefits, we will coordinate benefits with the other coverage under the coordination of benefits rules of the California Department of Managed Health Care. Those rules are incorporated into this *Evidence of Coverage*.

If both the other coverage and we cover the same Service, the other coverage and we will see that up to 100 percent of your covered medical expenses are paid for that Service. The coordination of benefits rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." The secondary coverage may reduce its payment to take into account payment by the primary coverage. You must give us any information we request to help us coordinate benefits.

If your coverage under this *Evidence of Coverage* is secondary, we may be able to establish a Benefit Reserve Account for you. You may draw on the Benefit Reserve Account during a calendar year to pay for your out-of-pocket expenses for Services that are partially covered by either your other coverage or us during that calendar year. If you are entitled to a Benefit Reserve Account, we will provide you with detailed information about this account.

If you have any questions about coordination of benefits, please call our Member Service Contact Center.

Medicare coverage

If you have Medicare coverage, we will coordinate benefits with the Medicare coverage under Medicare rules. Medicare rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." You must give us any information we request to help us coordinate benefits. Please call our Member Service Contact Center to find out which Medicare rules apply to your situation, and how payment will be handled.

Reductions

Employer responsibility

For any Services that the law requires an employer to provide, we will not pay the employer, and when we cover any such Services we may recover the value of the Services from the employer.

Government agency responsibility

For any Services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and when we cover any such Services we may recover the value of the Services from the government agency.

Injuries or illnesses alleged to be caused by third parties

If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered Services, you must pay

us Charges for those Services, except that the amount you must pay will not exceed the maximum amount allowed under California Civil Code Section 3040. Note: This "Injuries or illnesses alleged to be caused by third parties" section does not affect your obligation to pay Cost Sharing for these Services, but we will credit any such payments toward the amount you must pay us under this paragraph.

To the extent permitted or required by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney, but we will be subrogated only to the extent of the total of Charges for the relevant Services.

To secure our rights, we will have a lien on the proceeds of any judgment or settlement you or we obtain against a third party. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred.

Within 30 days after submitting or filing a claim or legal action against a third party, you must send written notice of the claim or legal action to:

Healthcare Recoveries, Inc.
Subrogation Mailbox
9390 Bunsen Parkway
Louisville, KY 40220

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on your injury or illness, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

If you have Medicare, Medicare law may apply with respect to Services covered by Medicare.

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers ordinarily charge to the general public ("General Fees"). However, these contracts may allow the providers to recover all or a portion of the difference between the fees paid by Kaiser Permanente and their General Fees by means of a lien claim under California Civil Code Sections 3045.1–3045.6 against a judgment or settlement that you receive from or on behalf of a third party. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

Medicare benefits

Your benefits are reduced by any benefits you have under Medicare except for Members whose Medicare benefits are secondary by law.

Surrogacy arrangements

If you enter into a Surrogacy Arrangement, you must pay us Charges for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed the payments or other compensation you and any other payee are entitled to receive under the Surrogacy Arrangement. A "Surrogacy Arrangement" is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Note: This "Surrogacy arrangements" section does not affect your obligation to pay Cost Sharing for these Services, but we will credit any such payments toward the amount you must pay us under this paragraph. After you surrender a baby to the legal parents, you are not obligated to pay Charges for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy our lien. The assignment and our lien

will not exceed the total amount of your obligation to us under the preceding paragraph.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receive
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:
Healthcare Recoveries, Inc.
Surrogacy Mailbox
9390 Bunsen Parkway
Louisville, KY 40220

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy arrangements" section and to satisfy those rights. You may not agree to waive, release, or reduce our rights under this "Surrogacy arrangements" section without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

U.S. Department of Veterans Affairs

For any Services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs, and when we cover any such Services we may recover the value of the Services from the Department of Veterans Affairs.

Workers' compensation or employer's liability benefits

You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered Services from the following sources:

- From any source providing a Financial Benefit or from whom a Financial Benefit is due
- From you, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law

Post-Service Claims and Appeals

This "Post-Service Claims and Appeals" section explains how to file a claim for payment or reimbursement for Services that you have already received. Please use the procedures in this section in the following situations:

- You have received Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services from a Non–Plan Provider and you want us to pay for the Services
- You have received Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Out-of-Area Urgent Care, Post-Stabilization Care, or emergency Ambulance Services) and you want us to pay for the Services
- You want to appeal a denial of an initial claim for payment

Please follow the procedures under "Grievances" in the "Dispute Resolution" section in the following situations:

- You want us to cover Services that you have not yet received
- You want us to continue to cover an ongoing course of covered treatment
- You want to appeal a written denial of a request for Services that require prior authorization (as described under "Medical Group authorization procedure for certain referrals")

Who May File

The following people may file claims:

- You may file for yourself
- You can ask a friend, relative, or attorney to file a claim for you by appointing him or her in writing as your authorized representative
- A parent may file for his or her child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the claim
- A court-appointed guardian may file for his or her ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the claim
- A court-appointed conservator may file for his or her conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for his or her principal

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services Department at a Plan Facility or by calling our Member Service Contact Center. Your written authorization must accompany the claim. You must pay the cost of anyone you hire to represent or help you.

Supporting Documents

You can request payment or reimbursement orally or in writing. Your request for payment or reimbursement, and any related documents that you give us, constitute your claim.

Claim forms for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

To file a claim in writing for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services, please use our claim form. You can obtain a claim form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers
- By calling our Member Services Contact Center at 1-800-464-4000 or 1-800-390-3510 (TTY users call 1-800-777-1370)

Claims forms for all other Services

To file a claim in writing for all other Services, you may use our Complaint or Benefit Claim/Request form. You can obtain this form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers
- By calling our Member Services Contact Center at 1-800-464-4000 (TTY users call 1-800-777-1370)

Other supporting information

When you file a claim, please include any information that clarifies or supports your position. For example, if you have paid for Services, please include any bills and receipts that support your claim. To request that we pay a Non–Plan Provider for Services, include any bills from the Non–Plan Provider. If the Non–Plan Provider states that they will file the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. When appropriate, we will request medical records from Plan Providers on your behalf. If you tell us that you have consulted with a Non–Plan Provider and are unable to provide copies of relevant medical records, we will contact the provider to request a copy of your relevant medical records. We will ask you to provide us a written authorization so that we can request your records.

If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should follow the steps in the written notice sent to you about your claim.

Initial Claims

To request that we pay a provider (or reimburse you) for Services that you have already received, you must file a claim. If you have any questions about the claims process, please call our Member Service Contact Center.

Submitting a claim for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

If you have received Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services from a Non–Plan

Provider, then as soon as possible after you received the Services, you must file your claim by mailing a completed claim form and supporting information to the following address:

Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 12923
Oakland, CA 94604-2923

Please call our Member Service Contact Center if you need help filing your claim.

Submitting a claim for all other Services

If you have received Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services), then as soon as possible after you receive the Services, you must file your claim in one of the following ways:

- By delivering your claim to a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By mailing your claim to a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By calling our Member Service Contact Center at 1-800-464-4000 (TTY users call 1-800-777-1370)
- By visiting our website at **kp.org**

Please call our Member Service Contact Center if you need help filing your claim.

After we receive your claim

We will send you an acknowledgement letter within five days after we receive your claim.

After we review your claim, we will respond as follows:

- If we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 30 days after we receive your claim
- If we need more information, we will ask you for the information before the end of the initial 30-day decision period. We will send our written decision no later than 15 days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in our letter, we will make our decision based on the information we have within 15 days after the end of that timeframe

If we pay any part of your claim, we will subtract applicable Cost Sharing from any payment we make to you or the Non–Plan Provider. If we deny your claim (if we do not agree to pay for all the Services you requested other than the applicable Cost Sharing), our letter will explain why we denied your claim and how you can appeal.

If you later receive any bills from the Non–Plan Provider for covered Services (other than bills for your Cost Sharing amount), please call our Member Service Contact Center for assistance.

Appeals

If we did not decide fully in your favor on a claim for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services from a Non–Plan Provider and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By mailing your appeal to the Claims Department at the following address:
  Kaiser Foundation Health Plan, Inc.
  Special Services Unit
  P.O. Box 23280
  Oakland, CA 94623
- By calling our Member Service Contact Center at 1-800-464-4000 (TTY users call 1-800-777-1370)

If we did not decide fully in your favor on a claim for Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services), you may submit your appeal in one of the following ways:

- By visiting our website at **kp.org**
- By mailing your appeal to the Member Services Department at a Plan Facility (please refer to *Your Guidebook* for addresses)
- In person from any Member Services office at a Plan Facility and from Plan Providers
- By calling our Member Service Contact Center at 1-800-464-4000 (TTY users call 1-800-777-1370)

When you file an appeal, please include any information that clarifies or supports your position. If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should contact or Member Service Contact Center.

Additional information regarding a claim for Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services). If we initially denied your request, you may send us information including comments, documents, and medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal. Please send all additional information to the address or fax mentioned in your denial letter.

Also, you may give testimony in writing or by telephone. Please send your written testimony to the address mentioned in our acknowledgement letter, sent to you within five days after we receive your appeal. To arrange to give testimony by telephone, you should call the phone number mentioned in our acknowledgement letter.

We will add the information that you provide through testimony or other means to your appeal file and we will review it without regard to whether this information was filed or considered in our initial decision regarding your request for Services.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our final decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

We will send you a resolution letter within 30 days after we receive your appeal. If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

External Review

You must exhaust our internal claims and appeals procedures before you may request external review unless we have failed to comply with the claims and appeals procedures described in this "Post-Service Claims and Appeals" section. For information about external review process, see "Independent Medical Review (IMR)" in the "Dispute Resolution" section.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (1-866-444-3272)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Dispute Resolution

We are committed to providing you with quality care and with a timely response to your concerns. You can discuss your concerns with our Member Services representatives at a Plan Facility, or you can call our Member Service Contact Center.

Grievances

This "Grievances" section describes our grievance procedure. A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. If you want to make a claim for payment or reimbursement for Services that you have already received, please follow the procedure in the "Post-Service Claims and Appeals" section.

Here are some examples of reasons you might file a grievance:

- You are not satisfied with the quality of care you received
- You received a written denial of Services that require prior authorization from the Medical Group and you want us to cover the Services
- Your treating physician has said that Services are not Medically Necessary and you want us to cover the Services

- You were told that Services are not covered and you believe that the Services should be covered
- You want us to continue to cover an ongoing course of covered treatment
- You are dissatisfied with how long it took to get Services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility
- We have terminated your membership and you disagree with that termination

If you are appealing a denial of a request for Services that require prior authorization, you must file your appeal within 180 days after the date you received our denial letter. Otherwise, you must file your grievance within 180 days of the date of the incident that caused your dissatisfaction. If you miss a deadline for filing a grievance, we may decline to review it.

Who May File

The following people may file a grievance:

- You may file for yourself
- You can ask a friend, relative, or attorney to file a grievance for you by appointing him or her in writing as your authorized representative
- A parent may file for his or her child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the grievance
- A court-appointed guardian may file for his or her ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the grievance
- A court-appointed conservator may file for his or her conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for his or her principal
- Your physician may act as your authorized representative with your verbal consent to request an urgent grievance as described under "Urgent procedure" in this "Grievances" section

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services Department at a Plan Facility or by calling our Member Service Contact Center. Your written authorization must accompany the grievance. You must pay the cost of anyone you hire to represent or help you.

Supporting Documents

You can file a grievance orally or in writing. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about Services you received.

To file a grievance in writing, please use our grievance form. You can obtain the form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers
- By calling our Member Services Contact Center at 1-800-464-4000 (TTY users call 1-800-777-1370)

When you file a grievance, please include any information that clarifies or supports your position. If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should contact or Member Service Contact Center.

Additional information regarding pre-service requests for Medically Necessary Services. You may send us information including comments, documents, and medical records that you believe support your grievance.

You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your pre-service request for Medically Necessary Services.

Also, you may give testimony in writing or by telephone. Please send your written testimony to the address mentioned in our acknowledgement letter. To arrange to give testimony by telephone, you should call the phone number mentioned in our acknowledgement letter.

We will add the information that you provide through testimony or other means to your grievance file and we will consider it in our decision regarding your pre-service request for Medically Necessary Services.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share

with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your grievance is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your grievance file.

Standard procedure

You must file your grievance in one of the following ways:

- By completing a grievance form at a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By mailing your grievance to a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By calling our Member Service Contact Center at 1-800-464-4000 (TTY users call 1-800-777-1370)
- By completing the grievance form on our website at **kp.org**

Please call our Member Service Contact Center if you need help filing a grievance.

We will send you an acknowledgement letter within five days after we receive your grievance. We will send you a resolution letter within 30 days after we receive your grievance. If you are requesting Services, and we do not decide in your favor, our letter will explain why and describe your further appeal rights.

Urgent procedure

If you want us to consider your grievance on an urgent basis, please tell us that when you file your grievance.

You must file your urgent grievance in one of the following ways:

- By calling our Expedited Review Unit toll free at 1-888-987-7247 (TTY users call 1-800-777-1370)
- By mailing a written request to:
  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 23170
  Oakland, CA 94623-0170
- By faxing a written request to our Expedited Review Unit toll free at 1-888-987-2252
- By visiting a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)

We will decide whether your grievance is urgent or non-urgent unless your attending health care provider tells us your grievance is urgent. If we determine that your grievance is not urgent, we will use the procedure described under "Standard procedure" in this "Grievances" section. Generally, a grievance is urgent only if one of the following is true:

- Using the standard procedure could seriously jeopardize your life, health, or ability to regain maximum function
- Using the standard procedure would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment
- A physician with knowledge of your medical condition determines that your grievance is urgent

If we respond to your grievance on an urgent basis, we will give you oral notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your grievance. We will send you a written confirmation within 3 days after that.

If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the California Department of Managed Health Care at any time at 1-888-HMO-2219 (TDD 1-877-688-9891) without first filing a grievance with us.

Department of Managed Health Care Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan toll free at **1-800-464-4000 (**TTY users call **1-800-777-1370)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained

unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet website **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Independent Medical Review (IMR)

If you qualify, you or your authorized representative may have your issue reviewed through the Independent Medical Review (IMR) process managed by the California Department of Managed Health Care. The Department of Managed Health Care determines which cases qualify for IMR. This review is at no cost to you. If you decide not to request an IMR, you may give up the right to pursue some legal actions against us.

You may qualify for IMR if all of the following are true:

- One of these situations applies to you:
  - you have a recommendation from a provider requesting Medically Necessary Services
  - you have received Emergency Services, emergency ambulance Services, or Urgent Care from a provider who determined the Services to be Medically Necessary
  - you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition
- Your request for payment or Services has been denied, modified, or delayed based in whole or in part on a decision that the Services are not Medically Necessary
- You have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for urgent grievances). The Department of Managed Health Care may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function

You may also qualify for IMR if the Service you requested has been denied on the basis that it is experimental or investigational as described under "Experimental or investigational denials."

If the Department of Managed Health Care determines that your case is eligible for IMR, it will ask us to send your case to the Department of Managed Health Care's Independent Medical Review organization. The Department of Managed Health Care will promptly notify you of its decision after it receives the Independent Medical Review organization's determination. If the decision is in your favor, we will contact you to arrange for the Service or payment.

Experimental or investigational denials

If we deny a Service because it is experimental or investigational, we will send you our written explanation within three days after giving you oral notice of our decision. We will explain why we denied the Service and provide additional dispute resolution options. Also, we will provide information about your right to request Independent Medical Review if we had the following information when we made our decision:

- Your treating physician provided us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we cover than the therapy being requested. "Life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity
- If your treating physician is a Plan Physician, he or she recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying his or her recommendation
- You (or your Non–Plan Physician who is a licensed, and either a board-certified or board-eligible, physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician's certification included a statement of the evidence relied upon by the

physician in certifying his or her recommendation. We do not cover the Services of the Non–Plan Provider

Note: You can request IMR for experimental or investigational denials at any time without first filing a grievance with us.

Binding Arbitration

For all claims subject to this "Binding Arbitration" section, both Claimants and Respondents give up the right to a jury or court trial and accept the use of binding arbitration. Insofar as this "Binding Arbitration" section applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this *Evidence of Coverage*. Such retroactive application shall be binding only on the Kaiser Permanente Parties.

Scope of arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *Evidence of Coverage* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. (Health Plan), including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of the legal theories upon which the claim is asserted
- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- Governing law does not prevent the use of binding arbitration to resolve the claim

Members enrolled under this *Evidence of Coverage* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeal procedure as applicable to Kaiser Permanente Senior Advantage and Medicare Cost Members
- Claims that cannot be subject to binding arbitration under governing law

As referred to in this "Binding Arbitration" section, "Member Parties" include:

- A Member
- A Member's heir, relative, or personal representative
- Any person claiming that a duty to him or her arises from a Member's relationship to one or more Kaiser Permanente Parties

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals
- KP Cal, LLC
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any Southern California Permanente Medical Group or The Permanente Medical Group physician
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties
- Any employee or agent of any of the foregoing

"Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts a claim as described above. "Respondent" refers to a Member Party or a Kaiser Permanente Party against whom a claim is asserted.

Rules of Procedure

Arbitrations shall be conducted according to the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of Procedure") developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from our Member Service Contact Center.

Initiating arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and telephone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include in the Demand for Arbitration all claims against Respondents that are based

on the same incident, transaction, or related circumstances.

Serving Demand for Arbitration

Health Plan, Kaiser Foundation Hospitals, KP Cal, LLC, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

Kaiser Foundation Health Plan, Inc.
Legal Department
1950 Franklin St., 17th Floor
Oakland, CA 94612

Service on that Respondent shall be deemed completed when received. All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing fee

The Claimants shall pay a single, nonrefundable filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or Respondents named in the Demand for Arbitration.

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling our Member Service Contact Center.

Number of arbitrators

The number of arbitrators may affect the Claimants' responsibility for paying the neutral arbitrator's fees and expenses (see the Rules of Procedure).

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of arbitrators' fees and expenses

Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the Rules of Procedure. In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs

Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this "Binding Arbitration" section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

General provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondent served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for non-economic losses, and the right to have an award for future damages conformed to periodic payments, shall

apply to any claims for professional negligence or any other claims as permitted or required by law.

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration" section. In accord with the rule that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration" section shall not be denied, stayed, or otherwise impeded because a dispute between a Member Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with a third party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2014, your last minute of coverage was at 11:59 p.m. on December 31, 2013). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *Evidence of Coverage* after your membership terminates, except as provided under "Payments after Termination" in this "Termination of Membership" section.

Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, your Group will notify you of the date that your membership will end (except that we will notify you of the date that your membership ends if you become ineligible for a reason described under "Health Plan eligibility requirements" in the "Who Is Eligible" section). Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2014, your last minute of coverage was at 11:59 p.m. on December 31, 2013).

Termination of *Agreement*

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. Your Group is required to notify Subscribers in writing if its *Agreement* with us terminates.

Termination for Cause

If you intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider, we may terminate your membership immediately by sending written notice to the Subscriber; termination will be effective on the date we send the notice. Some examples of fraud include:

- Misrepresenting eligibility information about you or a Dependent
- Presenting an invalid prescription or physician order
- Misusing a Kaiser Permanente ID card (or letting someone else use it)
- Giving us incorrect or incomplete material information. For example, you have entered into a Surrogacy Arrangement and you fail to send us the information we require under "Surrogacy arrangements" under "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section
- Failing to notify us of changes in family status or Medicare coverage that may affect your eligibility or benefits

If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future. We may also report criminal fraud and other illegal acts to the authorities for prosecution.

Termination of a Product or all Products

We may terminate a particular product or all products offered in a small or large group market as permitted or required by law. If we discontinue offering a particular product in a market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products to groups in a small or large group market, as applicable, we may terminate your Group's *Agreement* by sending you written notice at least 180 days before the *Agreement* terminates.

HIPAA Certificates of Creditable Coverage

The Health Insurance Portability and Accountability Act (HIPAA) requires employers or health plans to issue a "Certificate of Creditable Coverage" to Members whose coverage terminates. The certificate documents health care coverage and you can use it to prove prior creditable health care coverage if you seek new coverage after your membership terminates. When your membership terminates, or at any time upon request, we will mail the certificate to the Subscriber unless your Group has an agreement with us to mail the certificates. If you have any questions, please contact your Group.

Payments after Termination

If we terminate your membership for cause or for nonpayment, we will:

- Refund any amounts we owe your Group for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Emergency Services and Urgent Care" and "Dispute Resolution" sections. We will deduct any amounts you owe Health Plan or Plan Providers from any payment we make to you

State Review of Membership Termination

If you believe that we terminated your membership because of your ill health or your need for care, you may request a review of the termination by the California Department of Managed Health Care (please see "Department of Managed Health Care Complaints" in the "Dispute Resolution" section).

Continuation of Membership

If your membership under this *Evidence of Coverage* ends, you may be eligible to maintain Health Plan membership without a break in coverage under this *Evidence of Coverage* (Group coverage) or you may be eligible to convert to an individual (nongroup) plan.

Continuation of Group Coverage

If at any time you become entitled to continuation of Group coverage such as Cal-COBRA, please examine your coverage options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in higher premiums or you could be denied coverage entirely. Note: Medical history does not impact premiums or eligibility for our Individual–Conversion Plan and HIPAA Individual Plan described under "Conversion from Group Membership to an Individual Plan" in this "Continuation of Membership" section. However, the individual plan premiums and coverage will be different from the premiums and coverage under your Group plan.

COBRA

You may be able to continue your coverage under this *Evidence of Coverage* for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law (the Consolidated Omnibus Budget Reconciliation Act). COBRA applies to most employees (and most of their covered family Dependents) of most employers with 20 or more employees.

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Group for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and Premiums may change, and where to send your Premium payments.

As described in "Conversion from Group Membership to an Individual Plan" in this "Continuation of Membership" section, you may be able to convert to an individual (nongroup) plan if you don't apply for COBRA coverage, or if you enroll in COBRA and your COBRA coverage ends. Also, if you enroll in COBRA and exhaust the time limit for COBRA coverage, you may be able to continue Group coverage under state law as described under "Cal-COBRA" in this "Continuation of Group Coverage" section.

Cal-COBRA

If you are eligible for Cal-COBRA, you can continue coverage as described in this "Cal-COBRA" section if you apply for coverage in compliance with Cal-COBRA law and pay applicable Premiums.

Eligibility and effective date of coverage for Cal-COBRA after COBRA. If your group is subject to COBRA and your COBRA coverage ends, you may be able to continue Group coverage effective the date your COBRA coverage ends if all of the following are true:

- Your effective date of COBRA coverage was on or after January 1, 2003

- You have exhausted the time limit for COBRA coverage and that time limit was 18 or 29 months
- You do not have Medicare

You must request an enrollment application by calling our Member Service Contact Center within 60 days of the date of when your COBRA coverage ends.

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

Cal-COBRA enrollment and Premiums. Within 10 days of your request for an enrollment application, we will send you our application, which will include Premium and billing information. You must return your completed application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay the bill within 45 days after the date we issue the bill. The first Premium payment will include coverage from your Cal-COBRA effective date through our current billing cycle. You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

After that first payment, monthly Premium payments are due on or before the last day of the month preceding the month of coverage. The Premiums will not exceed 110 percent of the applicable Premiums charged to a similarly situated individual under the Group benefit plan except that Premiums for disabled individuals after 18 months of COBRA coverage will not exceed 150 percent instead of 110 percent.

Changes to Cal-COBRA coverage and Premiums. Your Cal-COBRA coverage is the same as for any similarly situated individual under your Group's *Agreement*, and your Cal-COBRA coverage and Premiums will change at the same time that coverage or Premiums change in your Group's *Agreement*. Your Group's coverage and Premiums will change on the renewal date of its *Agreement* (January 1), and may also change at other times if your Group's *Agreement* is amended. Your monthly invoice will reflect the current Premiums that are due for Cal-COBRA coverage, including any changes. For example, if your Group makes a change that affects Premiums retroactively, the amount we bill you will be adjusted to reflect the retroactive adjustment in Premiums. Your Group can tell you whether this *Evidence of Coverage* is still in effect and give you a current one if this *Evidence of Coverage* has expired or been amended. You can also request one from our Member Service Contact Center.

Cal-COBRA open enrollment or termination of another health plan. If you previously elected Cal-COBRA coverage through another health plan available through your Group, you may be eligible to enroll in Kaiser Permanente during your Group's annual open enrollment period, or if your Group terminates its agreement with the health plan you are enrolled in. You will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA. Please ask your Group for information about health plans available to you either at open enrollment or if your Group terminates a health plan's agreement.

In order for you to switch from another health plan and continue your Cal-COBRA coverage with us, we must receive your enrollment application during your Group's open enrollment period, or within 63 days of receiving the Group's termination notice described under "Group responsibilities." To request an application, please call our Member Service Contact Center. We will send you our enrollment application and you must return your completed application before open enrollment ends or within 63 days of receiving the termination notice described under "Group responsibilities." If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay the bill within 45 days after the date we issue the bill. You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

Termination for nonpayment of Cal-COBRA Premiums. If we do not receive the full amount of your Family's Premium payment on or before the last day of the month preceding the month of coverage, we will terminate the membership of everyone in your Family effective on the last day of the month for which we received a full Premium payment. This retroactive period will not exceed 60 days before the date we mail you a notice confirming termination of membership. If we do not receive full Premium payment on or before the last day of the month preceding the month of coverage, we will send a Notice of Termination (notice of nonreceipt of payment) to the Subscriber in accord with "Notices" in the "Miscellaneous Provisions" section. We will mail this notice at least 15 days before any termination of coverage and it will include the following information:

- A statement that we have not received full Premium payment and that we will terminate the memberships of everyone in your Family for nonpayment if we do not receive the required Premiums within 15 days after the date we mailed the notice confirming termination of membership
- The date and time when the memberships of everyone in your Family will end if we do not receive the Premiums

We will terminate your Family's memberships if we do not receive payment within 15 days of the date we mailed the Notice of Termination (notice of nonreceipt of payment). We will mail a notice confirming termination of membership, which will inform you of the following:

- That we have terminated the memberships of everyone in your Family for nonpayment of Premiums
- The date and time when the memberships of everyone in your Family ended
- Information explaining whether or not you can reinstate your memberships

Reinstatement of your membership after termination for nonpayment of Cal-COBRA Premiums. If we terminate your membership for nonpayment of Premiums, we will permit reinstatement of your membership twice during any 12-month period if we receive the amounts owed within 15 days of the date the notice confirming termination of membership was mailed to you. We will not reinstate your membership if you do not obtain reinstatement of your terminated membership within the required 15 days, or if we terminate your membership for nonpayment of Premiums more than twice in a 12-month period.

Termination of Cal-COBRA coverage. Cal-COBRA coverage continues only upon payment of applicable monthly Premiums to us at the time we specify, and terminates on the earliest of:

- The date your Group's *Agreement* with us terminates (you may still be eligible for Cal-COBRA through another Group health plan)
- The date you get Medicare
- The date your coverage begins under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have (or that does contain such an exclusion or limitation, but it has been satisfied)
- The date that is 36 months after your original COBRA effective date (under this or any other plan)
- The date your membership is terminated for nonpayment of Premiums as described under "Termination for nonpayment of Cal-COBRA Premiums" in this "Continuation of Membership" section

Note: If the Social Security Administration determined that you were disabled at any time during the first 60 days of COBRA coverage, you must notify your Group within 60 days of receiving the determination from Social Security. Also, if Social Security issues a final determination that you are no longer disabled in the 35th or 36th month of Group continuation coverage, your Cal-COBRA coverage will end the later of: (1) expiration of 36 months after your original COBRA effective date, or (2) the first day of the first month following 31 days after Social Security issued its final determination. You must notify us within 30 days after you receive Social Security's final determination that you are no longer disabled.

Group responsibilities. If your Group's agreement with a health plan is terminated, your Group is required to provide written notice at least 30 days before the termination date to the persons whose Cal-COBRA coverage is terminating. This notice must inform Cal-COBRA beneficiaries that they can continue Cal-COBRA coverage by enrolling in any health benefit plan offered by your Group. It must also include information about benefits, premiums, payment instructions, and enrollment forms (including instructions on how to continue Cal-COBRA coverage under the new health plan). Your Group is required to send this information to the person's last known address, as provided by the prior health plan. Health Plan is not obligated to provide this information to qualified beneficiaries if your Group fails to provide the notice. These persons will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this *Evidence of Coverage* for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group to find out how to elect USERRA coverage and how much you must pay your Group.

Coverage for a disabling condition

If you became Totally Disabled while you were a Member under your Group's *Agreement* with us and

while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates and is not renewed, we will cover Services for your totally disabling condition until the earliest of the following events occurs:

- 12 months have elapsed since your Group's *Agreement* with us terminated
- You are no longer Totally Disabled
- Your Group's *Agreement* with us is replaced by another group health plan without limitation as to the disabling condition

Your coverage will be subject to the terms of this *Evidence of Coverage*, including Cost Sharing, but we will not cover Services for any condition other than your totally disabling condition.

For Subscribers and adult Dependents, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months, and makes the person unable to engage in any employment or occupation, even with training, education, and experience.

For Dependent children, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the illness or injury makes the child unable to substantially engage in any of the normal activities of children in good health of like age.

To request continuation of coverage for your disabling condition, you must call our Member Service Contact Center within 30 days after your Group's *Agreement* with us terminates.

Conversion from Group Membership to an Individual Plan

After your Group notifies us to terminate your membership, we will send a termination letter to the Subscriber's address of record. The letter will include information about options that may be available to you to remain a Health Plan member.

Kaiser Permanente Conversion Plan

If you want to remain a Health Plan member, one option that may be available is an individual plan called "Kaiser Permanente Individual–Conversion Plan." You may be eligible to enroll in our Individual–Conversion Plan if you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section. Also, if you enroll in Group continuation coverage through COBRA, Cal-COBRA, or USERRA, you may be eligible to enroll in our Individual–Conversion Plan when your Group continuation coverage ends. The premiums and coverage under our Individual–Conversion Plan are different from those under this *Evidence of Coverage.*

To be eligible for our Individual–Conversion Plan, there must be no lapse in your coverage and we must receive your enrollment application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later). To request an application, please call our Member Service Contact Center.

If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay the bill within 45 days after the date we issue the bill. Because your coverage under our Individual–Conversion Plan begins when your Group coverage ends (including Group continuation coverage), your first payment to us will include coverage from when your Group coverage ended through our current billing cycle. You must send us the premium payment by the due date on the bill to be enrolled in our Individual–Conversion Plan.

You may not convert to our Individual–Conversion Plan if any of the following is true:

- You continue to be eligible for coverage through your Group (but not counting COBRA, Cal-COBRA, or USERRA coverage)
- Your membership ends because your Group's *Agreement* with us terminates and it is replaced by another plan within 15 days of the termination date
- We terminated your membership under "Termination for Cause" in the "Termination of Membership" section
- You live in the service area of a Region outside California, except that the Subscriber's or the Subscriber's Spouse's otherwise-eligible children may be eligible to be covered Dependents even if they live in (or move to) the service area of a Region outside California (please refer to "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section for more information)

HIPAA and other individual plans

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health care coverage for workers and their families when they change or lose their jobs. If you lose group health care coverage and meet

certain criteria, you are entitled to purchase individual (nongroup) health care coverage from any health plan that sells individual health care coverage.

Every health plan that sells individual health care coverage must offer individual coverage to an eligible person under HIPAA. The health plan cannot reject your application if you are an eligible person under HIPAA, you agree to pay the required premiums, and you live or work inside the plan's service area. To be considered an eligible person under HIPAA, you must meet the following requirements:

- You have 18 or more months of creditable coverage without a break of 63 days or more between any of the periods of creditable coverage or since the most recent coverage was terminated
- Your most recent creditable coverage was under a group, government, or church plan (COBRA and Cal-COBRA are considered group coverage)
- You were not terminated from your most recent creditable coverage due to nonpayment of premiums or fraud
- You are not eligible for coverage under a group health plan, Medicare, or Medicaid (Medi-Cal)
- You have no other health care coverage
- You have elected and exhausted any continuation coverage you were offered under COBRA or Cal-COBRA

For more information (including premiums and complete eligibility requirements), please refer to the Kaiser Permanente HIPAA Individual Plan evidence of coverage. To request a copy of the HIPAA Individual Plan evidence of coverage or for information about other individual plans, such as Kaiser Permanente for Individuals and Families plans, please call our Member Service Contact Center.

Miscellaneous Provisions

Administration of *Agreement*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of your Group's *Agreement*, including this *Evidence of Coverage*.

Advance directives

The California Health Care Decision Law offers several ways for you to control the kind of health care you will receive if you become very ill or unconscious, including the following:

- A *Power of Attorney for Health Care* lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your own views on life support and other treatments
- *Individual health care instructions* let you express your wishes about receiving life support and other treatment. You can express these wishes to your doctor and have them documented in your medical chart, or you can put them in writing and have that included in your medical chart

To learn more about advance directives, including how to obtain forms and instructions, contact the Member Services Department at a Plan Facility. You can also refer to *Your Guidebook* for more information about advance directives.

Agreement binding on Members

By electing coverage or accepting benefits under this *Evidence of Coverage*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *Evidence of Coverage*.

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *Evidence of Coverage*, your Group is required to inform you in accord with applicable law and your Group's *Agreement*.

Applications and statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *Evidence of Coverage*.

Assignment

You may not assign this *Evidence of Coverage* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

Attorney and advocate fees and expenses

In any dispute between a Member and Health Plan, the Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses.

Claims review authority

We are responsible for determining whether you are entitled to benefits under this *Evidence of Coverage* and we have the discretionary authority to review and evaluate claims that arise under this *Evidence of Coverage*. We conduct this evaluation independently by interpreting the provisions of this *Evidence of Coverage*. We may use medical experts to help us review claims. If coverage under this *Evidence of Coverage* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), then we are a "named claims fiduciary" to review claims under this *Evidence of Coverage*.

ERISA notices

This "ERISA notices" section applies only if your Group's health benefit plan is subject to the Employee Retirement Income Security Act (ERISA). We provide these notices to assist ERISA-covered groups in complying with ERISA. Coverage for Services described in these notices is subject to all provisions of this *Evidence of Coverage*.

Newborns' and Mother's Health Protection Act. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same Cost Sharing applicable to other medical and surgical benefits provided under this plan.

Governing law

Except as preempted by federal law, this *Evidence of Coverage* will be governed in accord with California law and any provision that is required to be in this *Evidence of Coverage* by state or federal law shall bind Members and Health Plan whether or not set forth in this *Evidence of Coverage*.

Group and Members not our agents

Neither your Group nor any Member is the agent or representative of Health Plan.

Health Insurance Counseling and Advocacy Program (HICAP)

For additional information concerning benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. HICAP provides health insurance counseling for California senior citizens. Call HICAP toll free at 1-800-434-0222 (TTY users call 711) for a referral to a HICAP office. HICAP is a free service provided by the state of California.

No waiver

Our failure to enforce any provision of this *Evidence of Coverage* will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Nondiscrimination

We do not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, language, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, or genetic information.

Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call our Member Service Contact Center as soon as possible to give us their new address. If a Member does not reside with the Subscriber, he or she should contact our Member Service Contact Center to discuss alternate delivery options.

Note: When we tell your Group about changes to this *Evidence of Coverage* or provide your Group other information that affects you, your Group is required to notify the Subscriber within 30 days (or five days if we terminate your Group's *Agreement*) after receiving the information from us.

Other formats for Members with disabilities

You can request a copy of this *Evidence of Coverage* in an alternate format (Braille, audio, electronic text file, or

large print) by calling our Member Service Contact Center.

Overpayment recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment or from any person or organization obligated to pay for the Services.

Privacy practices

Kaiser Permanente will protect the privacy of your protected health information. We also require contracting providers to protect your protected health information. Your protected health information is individually-identifiable information (oral, written, or electronic) about your health, health care services you receive, or payment for your health care. You may generally see and receive copies of your protected health information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your protected health information.

We may use or disclose your protected health information for treatment, health research, payment, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give protected health information to others, such as government agencies or in judicial actions. In addition, protected health information is shared with your Group only with your authorization or as otherwise permitted by law. We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices*, which provides additional information about our privacy practices and your rights regarding your protected health information is available and will be furnished to you upon request. To request a copy, please call our Member Service Contact Center. You can also find the notice at your local Plan Facility or on our website at kp.org.

Public policy participation

The Kaiser Foundation Health Plan, Inc., Board of Directors establishes public policy for Health Plan. A list of the Board of Directors is available on our website at **kp.org** or from our Member Service Contact Center. If you would like to provide input about Health Plan public policy for consideration by the Board, please send written comments to:

Kaiser Foundation Health Plan, Inc.
Office of Board and Corporate Governance Services
One Kaiser Plaza, 19th Floor
Oakland, CA 94612

Telephone access (TTY)

If you are hearing or speech impaired and use a text telephone device (TTY, also known as TDD) to communicate by phone, you can use the California Relay Service by calling 711 if a dedicated TTY number is not available for the telephone number that you want to call.

Helpful Information

Your Guidebook to Kaiser Permanente Services (Your Guidebook)

Please refer to *Your Guidebook* for helpful information about your coverage, such as:

- The types of covered Services that are available from each Plan Facility in your area
- How to use our Services and make appointments
- Hours of operation
- Appointments and advice phone numbers

You can get a copy of *Your Guidebook* by visiting our website at **kp.org** or by calling our Member Service Contact Center.

How to Reach Us

Appointments

If you need to make an appointment, please call us or visit our website:

Call	The appointment phone number at a Plan Facility (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for phone numbers)
Website	**kp.org** for routine (non-urgent) appointments with your personal Plan Physician or another Primary Care Physician

Not sure what kind of care you need?

If you need advice on whether to get medical care, or how and when to get care, we have licensed health care professionals available to assist you by phone 24 hours a day, 7 days a week:

Call The appointment or advice phone number at a Plan Facility (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for phone numbers)

Member Services

If you have questions or concerns about your coverage, how to obtain Services, or the facilities where you can receive care, you can reach us by calling, writing, or visiting our website:

Call **1-800-464-4000**

1-800-777-1370 (TTY)

24 hours a day, seven days a week (except holidays, and after 5 p.m. the day after Thanksgiving, Christmas Eve, and New Year's Eve)

Write Member Services Department at a Plan Facility (refer to *Your Guidebook* for addresses)

Website **kp.org**

If you have questions about a bill or about how much you have paid toward your Deductible or annual out-of-pocket maximum, or to get an estimate of Charges for Services that are subject to the Deductible, please call us:

Call **1-800-390-3507**

1-800-777-1370 (TTY)

Weekdays 7 a.m. to 5 p.m.

Authorization for Post-Stabilization Care

If you need to request authorization for Post-Stabilization Care as described under "Emergency Services" in the "Emergency Services and Urgent Care" section, please call us:

Call **1-800-225-8883** or the notification telephone number on your Kaiser Permanente ID card

711 (TTY)

24 hours a day, seven days a week

Help with claim forms for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

If you need a claim form to request payment or reimbursement for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits and Cost Sharing" section, or if you need help completing the form, you can reach us by calling or by visiting our website.

Call **1-800-464-4000** or **1-800-390-3510**

1-800-777-1370 (TTY)

24 hours a day, seven days a week (except holidays, and after 5 p.m. the day after Thanksgiving, Christmas Eve, and New Year's Eve)

Website **kp.org**

Submitting claims for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

If you need to submit a completed claim form for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits and Cost Sharing" section, or if you need to submit other information that we request about your claim, send it to our Claims Department:

Write Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 12923
Oakland, CA 94604-2923

Payment Responsibility

This "Payment Responsibility" section briefly explains who is responsible for payments related to the health care coverage described in this *Evidence of Coverage*. Payment responsibility is more fully described in other sections of the *Evidence of Coverage* as described below:

- Your Group is responsible for paying Premiums, except that you are responsible for paying Premiums if you have COBRA or Cal-COBRA (refer to "Premiums" in the "Premiums, Eligibility, and Enrollment" section and "COBRA" and "Cal-COBRA" under "Continuation of Group Coverage" in the "Continuation of Membership" section)
- Your Group may require you to contribute to Premiums (your Group will tell you the amount and how to pay)

- You are responsible for paying Cost Sharing for covered Services (refer to "Cost Sharing" in the "Benefits and Cost Sharing" section)
- If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider, or if you receive emergency ambulance Services, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us (refer to "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)
- If you receive Services from Non–Plan Providers that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services) and you want us to pay for the care, you must submit a grievance (refer to "Grievances" in the "Dispute Resolution" section)
- If you have coverage with another plan or with Medicare, we will coordinate benefits with the other coverage (refer to "Coordination of Benefits" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- In some situations, you or a third party may be responsible for reimbursing us for covered Services (refer to "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- You are responsible for paying the full price for noncovered Services