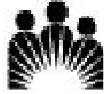

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Kaiser Foundation Health Plan, Inc.
Electronic Documents Policy

This policy document constitutes the explicit, written permission of Kaiser Foundation Health Plan, Inc., (Health Plan) for the Purchaser to use the accompanying Health Plan Enrollment and Member electronic documents under the following conditions:

These electronic documents must be used as provided, without additions, deletions, or other modifications.

These electronic documents are being provided in English. Translation of these documents by any person/organization other than by Health Plan (or certified translation agencies authorized by Health Plan) is prohibited. Please contact your Health Plan account representative to learn which documents are available in other languages.

These electronic documents may be posted to Purchaser Web sites.

Health Plan will provide updated versions of these electronic documents if there are substantive language changes. Purchasers must transfer the updated versions to their sites as soon as reasonably possible, but not later than 30 days after receipt of an updated document.

The Disclosure Form (DF) is subject to change. Health Plan will provide substantive DF language changes electronically to Purchasers. It is the Purchaser's responsibility to ensure that all changes are provided to employees. All electronic DF documents include a footnote containing an original issuance date to ensure accurate tracking.

If you have questions about our Electronic Documents Policy, or questions about a specific request for an electronic document, please contact your account representative for assistance.

Kaiser Foundation Health Plan, Inc.
California Division

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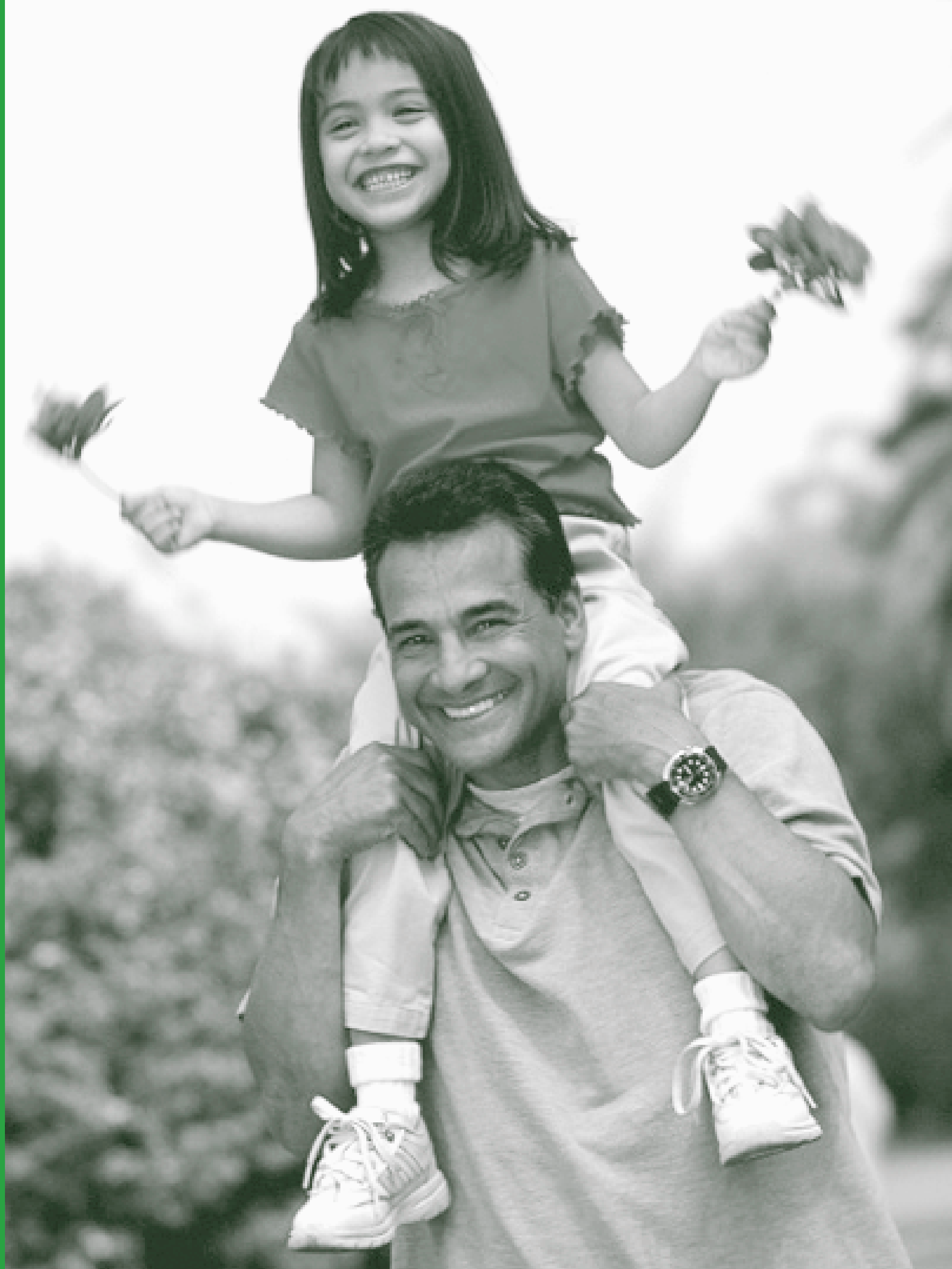

Kaiser Permanente Traditional Plan and Senior Advantage Disclosure Form and Evidence of Coverage for the University of California

Effective January 1, 2004

Kaiser Foundation Health Plan, Inc.
Northern and Southern California Regions
A nonprofit corporation

EFFECTIVE JANUARY 1, 2004

Kaiser Permanente Traditional Plan and Senior Advantage Disclosure Form and Evidence of Coverage for the University of California

This *Disclosure Form and Evidence of Coverage for the University of California (DF/EOC*) is divided into the following parts: "Section One, Traditional Plan" applies to Members enrolled in the Kaiser Permanente Traditional Plan, a non-Medicare Plan; "Section Two, Senior Advantage Plan" applies to Members enrolled in the Kaiser Permanente Senior Advantage Plan, a managed Medicare Plan; and "Section Three, General Information for All Members" provides information that applies to Members of both the Traditional and Senior Advantage Plans. Each section is clearly marked at the top of each page. Included are "Copayments and Coinsurance" charts for the Traditional and the Senior Advantage Plans, with comprehensive benefit descriptions that follow. The Traditional Plan "Copayments and Coinsurance"chart is on pages 12 through 15. The Senior Advantage Plan "Copayments and Coinsurance"chart is on pages 94 through 98.

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SECTION ONE

Kaiser Permanente Traditional Plan

Kaiser Permanente

Disclosure Form and

Evidence of Coverage

for the

University of California

Effective January 1, 2004

Member Service Call Center

1-800-464-4000
7 a.m. to 7 p.m., seven days a week

Hearing and speech impaired
1-800-777-1370 (TTY)

www.members.kp.org

SECTION ONE

Kaiser Permanente Traditional Plan

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Traditional Plan Summary of Changes Effective January 1, 2004

Unless otherwise indicated, effective January 1, 2004, the following is a summary of the most important changes and clarifications that will apply to your Traditional Plan coverage for the year 2004:

■ Benefit and Copayment changes

Please refer to the "Benefits" section of this *Disclosure Form/Evidence of Coverage (DF/EOC)* for benefit Descriptions and the "Copayments and Coinsurance" section for the amount Members must pay for covered benefits. Benefits are also subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.

Dental Services for radiation treatment and dental anesthesia. We have added "Dental Services for radiation treatment and dental anesthesia" to the "Benefits" section to clarify our coverage of dental-related Services.

Drug refills. We have added a provision saying that Members may be able to obtain refills through our Web site at *www.members.kp.org.* Also, most Plan Pharmacies offer refills by mail, but a few Plan Pharmacies don't dispense covered refills (Members should refer to their *Guidebook to Kaiser Permanente Services* or ask their Plan Pharmacy for details).

Durable medical equipment (DME). We have clarified DME coverage for Traditional Plan Members who live outside our Service Area. We do not cover most DME for use in homes outside our Service Area (for example, wheelchairs and oxygen), but our DME formulary guidelines allow a few DME items (such as crutches and canes) to be picked up from Plan Facilities. We have also added information about our DME formulary and how we maintain it.

Home health care. We have revised our home health care description for clarity. Also, we have added these two 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; or
- Care in the home if the home is not a safe and effective treatment setting.

We deleted the exclusion under home health care relating to custodial care because it was unnecessary. Custodial care is a general exclusion that applies to all benefits (except covered hospice care) as described in the "Exclusions" section of this *DF/EOC.*

Mental health group therapy visits. Mental health group visits will be provided at one-half the mental health individual visit Copayment, rounded down to the nearest dollar.

Ostomy and urological supplies. We have created a soft goods formulary for ostomy and urological supplies. Previously these items were included in

the durable medical equipment formulary. We have also added information about our soft goods formulary and how we maintain it.

Out-of-Pocket Maximum. We have expanded the list of Services that apply to the annual Out-of-Pocket Maximum (please refer to the "Copayments and Coinsurance" section for the Services that apply to the maximum).

Physical, occupational, and speech therapy and multidisciplinary rehabilitation Services. We have moved the benefit description to the "Outpatient care" and "Hospital inpatient care" sections.

Transplant Services. We have removed the exclusion for nonhuman and artificial organs because we cover Medically Necessary transplants as described in the "Transplant Services" section.

Eligibility, enrollment, and changes to our Service Area

The following changes have been made to provisions concerning eligibility, enrollment, and our Service Area:

- Eligibility has been expanded to include Subscribers who live **or work** inside the Service Area at the time of enrollment (see "Service Area eligibility requirements" in the "Who is eligible" section of this *DF/EOC*).
- The "Service Area" section in "Section Three, General Information for All Members" includes ZIP code revisions and we have clarified that ZIP codes can change at any time when the U.S. Postal Service makes a change.
- We have clarified in the "Service Area" section in "Section Three, General Information for All Members" in this *DF/EOC* that we may expand the Service Area at any time by giving notice to your Group.
- The "Who is eligible" section of this *DF/EOC* describes a Membership restriction for persons who live in or move to the service area of a Region outside California. We have revised the list of persons who are not subject to this limitation. The following persons are not ineligible solely because they live in a service area of a Region outside California (changes are underlined): <u>(1) a Subscriber who works inside our Service Area, (2) the Subscriber's or the Subscriber's Spouse's children</u>, and (3) Members who are eligible under this *DF/EOC* because of COBRA, Cal-COBRA, or USERRA coverage.
- The following persons are barred from enrollment (changes are underlined):
  - persons who have had their entitlement to receive Services through Health Plan either <u>rescinded</u> or terminated for cause cannot enroll; or
  - persons who had entitlement to receive Services through Health Plan terminated for failure to pay individual (nongroup) Plan Dues or failure to pay any amounts owed to Health Plan or a Plan Provider cannot enroll, <u>unless we agree to allow you to enroll after you pay</u> all amounts owed by you and your Dependents.
- We have clarified that a Subscriber may enroll an otherwise-eligible

child in response to a court or administrative order requiring the Subscriber to provide health coverage for the child.

Exclusions, Limitations, Coordination of Benefits, and Reductions

The following changes have been made to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section:

- We clarified that when a Service is not covered, all Services related to the noncovered Service are excluded, except that this exclusion does not apply to Services we would otherwise cover to treat complications of the noncovered Service.
- We have deleted the exclusion for Services not available within our Service Area.
- We have added that speech therapy Services to treat social, behavioral, or cognitive delays in speech or language development are not covered unless Medically Necessary.
- We have revised the "Limitations" section to state that we will do our best to provide or arrange for our Members' health care needs in the event of unusual circumstances that delay or render impractical the provision of Services under this *DF/EOC*, such as 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 disputes.

How to Obtain Services and Plan Facilities

We have clarified the "How to Obtain Services" section to provide additional information about Medical Group authorization procedures. We have created a new section called "Plan Facilities," which lists all Plan Hospitals and most Plan Medical Offices. Also, the "Definitions" section has been revised to address the new section in the definitions of Plan Hospital, Plan Medical Office, Plan Provider, Plan Facilities, and Plan Pharmacy.

Post-stabilization Care

We have clarified the description of Post-stabilization Care to include more information about Medically Necessary transportation. Please refer to the "Emergency, Urgent, and Routine Care" section in this *DF/EOC* for coverage information.

Requests for payment or Services and dispute resolution

We have clarified when Members may ask the Department of Managed Health Care for assistance and we have revised the description of Independent Medical Review (IMR) for clarity. Effective July 1, 2003, Members may file a grievance through our Web site at *www.members.kp.org*. Also, we have clarified who may file a grievance.

Termination for cause

We have revised our termination-for-cause provision as follows:

- We have clarified that a Membership may be terminated for cause if the Member commits theft from Health

Plan, from a Plan Provider, or at a Plan Facility.

- We have clarified the termination effective date.
- We may report fraud and other illegal acts to the authorities for prosecution.

Termination for nonpayment of other Charges

We revised this provision to say that we may terminate Membership if a Member fails to pay any amount that he or she owes Health Plan or a Plan Provider. We will send written notice of the termination to the Subscriber at least 15 days before the termination date. If we receive full payment before the termination date, we will not terminate the Membership. Also, if we terminate the Membership for nonpayment of other Charges, we will reinstate the Membership without a lapse in coverage if we receive full payment on or before the next scheduled payment due date.

Persons whose Memberships are terminated for nonpayment of other Charges may not enroll in Health Plan unless all amounts owed have been paid, and then, only if we approve the enrollment.

Termination and continuation of coverage

We have created a new section called "Continuation of Membership." It discusses the options to continue coverage through your Group and under an individual (nongroup) Plan. This section addresses requirements under AB1401, which allows for continuation of group coverage under Cal-COBRA when COBRA coverage has been exhausted after 18 or 29 months.

Members must call us to apply for Cal-COBRA coverage or individual (nongroup) coverage within 63 days of the date of our termination letter, or of their Membership termination date, whichever date is later.

Also, Members will now be eligible for conversion to our individual (nongroup) Plan if your Group's *Agreement* with us terminates, unless it is replaced by another Plan within 15 days of the termination date.

Terminology (defined terms)

The following definitions have been added or revised for clarity (refer to the "Definitions" section for more information):

- Charges
- Coinsurance
- Copayment
- Emergency Care
- Plan Facility
- Plan Hospital
- Plan Medical Office
- Plan Pharmacy
- Plan Provider
- Post-stabilization Care
- Service Area (see discussion in "Eligibility, enrollment, and changes to our Service Area" above)
- Skilled Nursing Facility

Copayments and Coinsurance

This section lists Kaiser Permanente Traditional Plan Copayments and Coinsurance only. To learn what is covered for each benefit **(including any visit and day limits),** please refer to the identical heading in the "Benefits" section (also refer to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section, which applies to all benefits).

Copayments or Coinsurance are due when you receive Services, but for items ordered in advance, you pay the Copayment or Coinsurance in effect on the order date (though we will not cover the item unless you still have coverage for it on the date you receive it). In some cases, we may agree to bill you for your Copayment or Coinsurance. If we agree to bill you, we will increase the amount by $13.50 and mail you a bill for the entire amount.

Copayments

Annual Out-of-Pocket Maximum:

One Member	$1,500
Subscriber and all of his or her Dependents	$3,000

Category	***Copayment***
Hospital inpatient care	
Hospital inpatient care, including physician Services	$250 per admission
Outpatient care	
Primary and specialty care visits (includes routine and urgent care appointments)	$10 per visit
Gynecological visits	$10 per visit
Pediatric visits	$10 per visit
Scheduled prenatal care and the first postpartum visit	No charge
Well-child preventive care visits (age 23 months or younger)	No charge
Outpatient surgery	$10 per procedure
Allergy testing visits	$10 per visit
Allergy injection visits	$5 per visit
Blood, blood products, and their administration	No charge
Immunization/Inoculation	No charge
Ambulance Services	
Emergency ambulance Services	No charge
Nonemergency ambulance Services as defined in the "Benefits" section	No charge
Chemical dependency Services	
Inpatient detoxification	$250 per admission
Outpatient individual therapy	$10 per visit
Outpatient group therapy	$5 per visit
Transitional residency recovery Services	$100 per admission

Category	*Copayment*
Dental Services for radiation treatment, dental anesthesia	
Dental Services for radiation treatment	$10
Dental anesthesia	The amount you would pay for hospital inpatient care or outpatient surgery depending on the setting
Dialysis care	
Inpatient care	$250 per admission
Physician office visits	$10 per visit
Dialysis treatment visits	$10 per visit
Drugs, supplies, and supplements	
Items described in the "Benefits" section under the heading "Administered drugs and self-administered IV drugs"	No charge
Diabetes urine-testing supplies	No charge (up to a 100-day supply)
Certain insulin-administration devices	$10 (up to a 100-day supply)
Items described in the "Benefits" section under the heading "Outpatient drugs, supplies, and supplements"	$10 generic/$20 brand name (up to a 100-day supply, or 3 cycles for oral contraceptives)
Copayments and Coinsurance for the following are as indicated:	
Amino acid-modified products used to treat congenital errors of amino acid metabolism and elemental dietary enteral formula when used as a primary therapy for regional enteritis	No charge (up to a 30-day supply)
Emergency contraceptive pills	No charge
Drugs for the treatment of infertility	50% Coinsurance (up to a 100-day supply)
Drugs related to the treatment of sexual dysfunction disorders: Episodic drugs are provided up to a supply maximum of 27 doses in any 100-day period	50% Coinsurance (up to a 100-day supply)
Maintenance (nonepisodic) drugs that require doses at regulated intervals	50% Coinsurance (up to a 100-day supply)

Note: *You will pay the Copayment or Charges for drugs, supplies, and supplements, whichever is less.*

Limitation: *The day supply dispensed at the Copayment and Coinsurance may be reduced (a) to a 30-day supply maximum in any 30-day period for specific drugs (please call our Member Service Call Center for the current list of these drugs), or (b) if the pharmacy limits the amount dispensed because the drug is in limited supply in the market. Also, the Copayment or Coinsurance applies to each prescription as prescribed by a Plan Physician not to exceed a 100-day supply. Members must pay Charges for any quantities dispensed that exceed the applicable supply maximum.*

Category	Copayment
Durable medical equipment (DME)	
Durable medical equipment used during a covered stay in a Plan Hospital or Skilled Nursing Facility	No charge
Durable medical equipment for use in the home and/or replacement	No charge
Emergency Department visits	
Emergency Department visits	$50 per visit (waived if admitted directly to the hospital)
Family planning Services	
Inpatient Services	$250 per admission
Outpatient visits	$10 per visit
Health education	
Individual visits	$10 per visit
All other covered Services	No charge
Hearing Services	
Hearing tests	$10 per visit
Hearing aid(s) every 36 months, as described in the “Benefits” section	Up to a $1,000 allowance per aid, per ear
Home health care	
Home health care	No charge
Hospice care	
Hospice care	No charge
Imaging, laboratory, and special procedures	
Imaging, laboratory, special procedures, and ultraviolet light treatment visits	No charge
Infertility Services	
Office visits	50% Coinsurance
Outpatient surgery	50% Coinsurance
Imaging, laboratory, and special procedures	50% Coinsurance
Hospital inpatient care	50% Coinsurance
Prescribed drugs obtained at Plan Pharmacies	50% Coinsurance (up to a 100-day supply)

Category	Copayment

Mental health Services

Inpatient psychiatric care and hospital alternative Services	$250 per admission
Hospital alternative Services	No charge
Outpatient visits	$10 per visit
Group therapy visits	$5

Ostomy and urological supplies

Ostomy and urological supplies	No charge

Physical, occupational, and speech therapy, and multidisciplinary rehabilitation Services

Inpatient Services	No charge
Outpatient visits	$10 per visit

Prosthetic and orthotic devices

Covered devices	No charge

Reconstructive surgery

Inpatient Services	$250 per admission
Outpatient visits	$10 per visit
Outpatient surgery	$10 per procedure

Services associated with Clinical Trials

The amount you would pay if the Services were not provided in connection with a Clinical Trial

Skilled Nursing Facility care

Care in a Skilled Nursing Facility	No charge

Transplant Services

Inpatient care	$250 per admission
Physician office visits	$10 per visit

Urgent care

In-area	$10 per visit at a Plan Facility; Not covered at a Non-Plan Facility
Out-of-area	$10 per visit if seen in a physician's office; $50 per visit when seen in the emergency room at a non-Plan Facility

Vision Services

Eye exams	$10 per visit

Introduction

This *Disclosure Form and Evidence of Coverage (DF/EOC)* describes the Kaiser Permanente Traditional Plan health care provided under the *Agreement* between Kaiser Foundation Health Plan, Inc., and the University of California. For benefits provided under any other Health Plan program, refer to that Plan's *Evidence of Coverage*. In this *DF/EOC,* Kaiser Foundation Health Plan, Inc., is sometimes referred to as "Health Plan," "we," or "us." Members are sometimes referred to as "you" or "your." Some capitalized terms have special meaning in this *DF/EOC;* please see the "Definitions" section in "Section Three, General Information for All Members" of this booklet for terms you should know.

We provide covered Services directly to our Members through an integrated medical care program. Our Health Plan, Hospitals, and 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, and other benefits described in the "Benefits" section.

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* DF/EOC *completely so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

When you join Kaiser Permanente, you are enrolling in one of two Regions (Northern or Southern California). When you temporarily visit the other California Region, you may receive care as a visiting Member. Please keep this booklet. If you enroll with Kaiser Permanente, it becomes your *Evidence of Coverage.*

Term of this *Disclosure Form and Evidence of Coverage*

This *DF/EOC* is in effect from January 1, 2004, to December 31, 2004. Your Group's Benefits Administrator can confirm that this *DF/EOC* is still in effect and can provide you with a current one if this *DF/EOC* has expired.

A special note for Members with Medicare and Annuitants

This section, "Section One," of this *DF/EOC* is not intended for most Medicare beneficiaries. For Members entitled to Medicare, Kaiser Permanente offers the Kaiser Permanente Senior Advantage Plan described in "Section Two," the Senior Advantage portion of this *DF/EOC*.

You should confirm with your Benefits Administrator that "Section One" of this *DF/EOC* applies to you rather than "Section Two." If you are enrolled in the Senior Advantage Plan, information about your coverage and Copayments and Coinsurance is provided in "Section Two" of this booklet, titled "Kaiser Permanente Senior Advantage Plan *Disclosure Form and Evidence of Coverage* for the University of California."

Annuitants and their Dependents who become eligible for Medicare hospital insurance (Part A) as primary coverage must enroll and remain in both the hospital (Part A) and the medical (Part B) portions of Medicare. This includes those who are entitled to Medicare benefits through their own or their Spouse's non-University employment. Annuitants or Dependents who are eligible for, but decline to enroll in, both parts of Medicare will be assessed an offset fee to cover the increased costs of remaining in the non-Medicare Plan. Annuitants or Dependents who are not eligible for Medicare Part A will not be assessed an offset fee. A notarized affidavit attesting to their ineligibility for Medicare Part A will be required. Forms for this purpose may be obtained from the University of California Customer Service Center toll free at **1-800-888-8267.** (Annuitants/Dependents who are not entitled to Social Security and Medicare Part A will not be required to enroll in Medicare Part B.)

Note: 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 to existing Members who are eligible for Medicare (including when you turn age 65).

You should contact Social Security three months prior to your 65th birthday to inquire about your eligibility and how to enroll in the hospital (Part A) and medical (Part B) parts of Medicare. If you qualify for disability income benefits from Social Security, contact the Social Security office for information about when you will be eligible for Medicare enrollment.

To enroll in a University-sponsored Medicare Plan, simply complete a Medicare Declaration form. This notifies the University that you are covered by the hospital (Part A) and medical (Part B) parts of Medicare.

Medicare Declaration forms are available from the University of California Customer Service Center.

Upon receipt by the University of confirmation of Medicare enrollment, the Annuitant or Dependent will be changed from the current carrier's non-Medicare Plan to a Medicare Plan. Annuitants and Dependents are required to transfer to the Plan for Medicare enrollees.

This requirement does not apply to active employees and their Dependents who are age 65 or older, and who are currently eligible for medical coverage through their employer.

For further information, please contact the University of California Customer Service Center toll free at **1-800-888-8267.**

Who is eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements 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.

- **Service Area eligibility requirements**

  The Subscriber must live or work in our Service Area at the time he or

she enrolls. The "Service Area" section of "Section Three, General Information for All Members" describes our Service Area and how it may change. You cannot enroll or continue enrollment as a Subscriber or Dependent if you live in or move to a Region outside California except as described below. If you move anywhere else outside our Service Area after enrollment, you can continue your Membership as long as you meet all other eligibility requirements. However, you must receive covered Services from Plan Providers inside our Service Area, except as described in the "Emergency, Urgent, and Routine Care" section about Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care received from non-Plan Providers and in "Our Visiting Member Program" in the "How to Obtain Services" section.

Regions outside California. If you live in or move to the service area of a Region outside of California, you are not eligible for Membership under this *DF/EOC* (unless one of the exceptions listed below applies to you). Please contact your Group's Benefits Administrator to learn about your Group health care options. You may be able to enroll in the new service area if there is an agreement between your Group and the Region, but the coverage, Dues, and eligibility requirements might not be the same in the other service area.

Exceptions: This restriction does not apply to the following persons (see "Our Visiting Member Program" in the "How to Obtain Services" section for information about benefits when you are in another service area):

- A Subscriber who works inside our Service Area.
- The Subscriber's or the Subscriber's Spouse's children.
- Members who are eligible under this *DF/EOC* because of COBRA, Cal-COBRA, or USERRA coverage (please refer to the "Continuation of Membership" section for information about COBRA, Cal-COBRA, and USERRA coverage).

For the purposes of this eligibility rule, these non-California service areas may change on January 1 of each year. For more information, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

The University of California establishes its own medical plan eligibility criteria for employees and Annuitants based on the University of California Group Insurance Regulations. Portions of these regulations are summarized below.

■ Subscriber

Employee: You are eligible to enroll if you are appointed to work at least overall 50 percent time for 12 months or more, or are appointed at 100 percent time for three months or more, or have accumulated 1,000 hours while on pay status in a 12-month period. To remain eligible, you must maintain an average regular paid time of at least 17.5 hours per week. If your appointment is at least 50 percent time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

Annuitant (including Survivor Annuitant):

You may continue University medical plan coverage when you retire or start collecting disability or survivor benefits from the University of California retirement plan, or any other defined benefit plan to which the University contributes.

These conditions apply, provided:

1. You were in a University medical plan immediately before retiring;
2. The effective date of your Annuitant status is within 120 calendar days of the date employment ends (or the date of the employee's/Annuitant's death in the case of a Survivor Annuitant);
3. Your medical coverage is continuous from the date employment ends;
4. You elect to continue coverage at the time of retirement; and
5. You meet the University's service credit requirements for Annuitant medical eligibility.

■ Eligible Dependents

Spouse: Your legal Spouse. Unless you are a Survivor Annuitant, you may not enroll your legal Spouse.

Children: Any of your or your Spouse's natural or legally adopted (or children placed with you for adoption) children who are unmarried, are not emancipated minors, and are under age 23.

The following unmarried children (but not including foster children) are also eligible:

a. Any unmarried stepchildren under age 23 who reside with you, who are dependent upon you or your Spouse for at least 50 percent of their support, and who are your or your Spouse's Dependents for income tax purposes.
b. Any unmarried grandchildren under age 23 who reside with you, who are dependent upon you or your Spouse for at least 50 percent of their support, and who are your or your Spouse's Dependents for income tax purposes.
c. Any unmarried children under age 18 for whom you are the legal guardian, who reside with you, who are dependent upon you for at least 50 percent of their support, and who are your Dependents for income tax purposes.

Your signature on the enrollment form or, if you enroll electronically, your electronic enrollment, attests to these conditions in (a), (b), and (c) above. You will be asked to submit a copy annually of your federal income tax return (IRS form 1040 or IRS equivalent showing the covered Dependents and your signature) to the University to verify income tax dependency.

Any unmarried child, as defined above (except a child for whom you are the legal guardian), who is incapable of self-sustaining employment due to a physical or mental handicap may continue to be covered past age 23 provided: The child is dependent upon you for at least 50 percent of his or her support, is your Dependent for income tax purposes, the incapacity began before age 23, the child was enrolled in a medical plan before age 23, and coverage is continuous. Application must be made to Kaiser Permanente 31 days prior to the child's 23rd birthday and is subject to approval by the Plan. Kaiser Permanente may periodically request proof of continued

disability. Your signature on the enrollment form or, if you enroll electronically, your electronic enrollment, attests to these conditions. You will be asked to submit a copy annually of your federal income tax return (IRS form 1040 or IRS equivalent showing the covered Dependent and your signature) to the University to verify income tax dependency.

Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan. If enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired employee with an overage, incapacitated Dependent child, you may apply for coverage for that child under the same general terms as a current employee. The child must have had continuous group medical coverage since age 23, and you must apply for coverage during your Period of Initial Eligibility (PIE).

If the overage, handicapped child is not the employee's, Annuitant's, or Survivor Annuitant's natural or legally adopted child, the child must reside with the employee, Annuitant, or Survivor Annuitant in order for the coverage to be continued past age 23.

Other eligible Dependents: You may enroll a same-sex domestic partner and their eligible children, or continue enrollment for an adult Dependent relative (enrolled prior to January 1, 2004) as set forth in the University of California Group Insurance Regulations. For information on who qualifies and on the requirements to enroll or continue enrollment for these Dependents, contact your local Benefits Office.

Eligible persons may be covered under only one of the following categories: as an employee, as an Annuitant, as a Survivor Annuitant, or as a Dependent, but not under any combination of these. If both husband and wife are eligible, each may enroll separately or one may cover the other as a Dependent. If they enroll separately, neither may enroll the other as a Dependent. Eligible children may be enrolled under either parent's coverage, but not under both.

The University and/or Health Plan reserves the right to periodically request documentation to verify eligibility of Dependents. Such documentation could include a marriage certificate, birth certificate(s), adoption records, or other official documentation.

■ Persons barred from enrolling in Health Plan

- Persons who have had their entitlement to receive Services through Health Plan either rescinded or terminated for cause cannot enroll.
- Persons who had entitlement to receive Services through Health Plan terminated for failure to pay individual (non-group) Plan Dues or failure to pay any amounts owed to Health Plan or a Plan Provider cannot enroll, unless we agree to allow you to enroll after you pay all amounts owed by you and your Dependents.

Enrollment

Your Group is required to inform you when you are eligible to enroll and your effective date of coverage.

You may enroll yourself and any eligible Dependents during your Period of Initial Eligibility (PIE). The PIE starts the day you become eligible for benefits or acquire a newly eligible Dependent.

You may enroll your newly eligible Dependent during his or her PIE. The PIE starts the day your Dependent becomes eligible for benefits.

a. For a new Spouse, eligibility begins on the date of marriage. Survivor Annuitants may not add new Spouses to their coverage.
b. For a newborn child, eligibility begins on the child's date of birth if the Subscriber enrolls the child within 31 days after birth.
c. For newly adopted children, eligibility begins on the earlier of:
    i. The date the employee or the employee's Spouse has the legal right to control the child's health care, or
    ii. The date the child is placed in the employee's physical custody.

If not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date that the adoption becomes final.

If you decline enrollment for yourself or your eligible Dependents because of other medical plan coverage and that coverage ends, you may in the future be able to enroll yourself or your eligible Dependents in a medical plan for which you are eligible provided that you enroll within the PIE. The PIE starts on the day the other coverage is no longer in effect.

If you move or are transferred out of a University HMO plan's service area, or will be away from the plan's Service Area for more than two months, you will have a PIE to enroll in another University medical plan. The PIE begins with the effective date of the move or the date the employee leaves the Service Area.

A PIE ends on the date 31 days after it begins (or on the preceding business day for the local Accounting or Benefits Office if the 31st day is on a weekend or a holiday).

To enroll yourself or an eligible Dependent, submit an enrollment form to the local Accounting or Benefits Office (or enroll electronically) during the PIE.

You and your eligible Dependents may also enroll by submitting an enrollment form during a group open enrollment period established by the University.

If you or your eligible Dependent fail to enroll during a PIE or open enrollment period, you may enroll at any other time upon completion of a 90-consecutive-calendar-day waiting period. The 90-day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits Office and ends 90 consecutive calendar days later.

An employee already enrolled in employee and child(ren) and family coverage may add additional children at any time after their PIE. Retroactive coverage for such enrollment is limited to the later of:

a. A maximum of 60 days prior to the date your Dependent is enrolled (either by receipt of his/her enrollment form by the local Accounting or Benefits Office or by electronic enrollment), or

b. The date the Dependent became eligible.

Special enrollment due to loss of other coverage

An employee and the employee's eligible Dependents may enroll within 30 days of losing other coverage by submitting to your Group an enrollment or change of enrollment application or in a form agreed upon by your Group and Health Plan. The employee requesting enrollment must have previously waived coverage for self or family Dependents when originally eligible because of the other coverage. In addition, the loss of the other coverage must be due to ineligibility to continue the other coverage, group continuation of coverage has expired, or the other employer has ceased making contributions toward the other coverage and the loss of coverage is not due to nonpayment or cause. The employee must enroll or be enrolled in order to enroll a family Dependent.

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 that the Subscriber signs an enrollment or change of enrollment application.

For specific University of California enrollment provisions, please see the "Enrollment" section on the previous page.

Special enrollment due to new Dependents

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents within 30 days of marriage, birth, adoption, or placement for adoption by submitting to your Group an enrollment or change of enrollment application in a form agreed upon by your Group and Health Plan.

The effective date of an enrollment resulting from marriage is no later than the first day of the month following the date that the Subscriber signs an enrollment or change of enrollment application. Enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, adoption, or placement for adoption. For specific University of California enrollment provisions, please see the "Enrollment" section above.

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 coverage for a child who meets the eligibility requirements as a Dependent, the Subscriber may add the child as a Dependent by submitting to Group an enrollment or change of enrollment application in a form agreed upon by Group and Health Plan.

Effective date of coverage

Coverage for newly eligible employees and their Dependents is effective on the date of eligibility, provided they are enrolled (either by receipt of an enrollment form by the local Accounting or Benefits Office or by electronic enrollment) within the PIE.

Coverage for newly eligible Dependents is effective on the date the Dependent becomes eligible, provided they are enrolled (either by receipt of an enrollment form by the local Accounting or Benefits Office or by electronic enrollment) within the PIE.

Exceptions to this rule:

- A newborn child is covered from the moment of birth if the Subscriber enrolls the child within 31 days after birth. Any Dues required for the newborn will be effective the first of the month following birth;
- If the newborn child is not enrolled within 31 days, the newborn is covered only through the calendar month of birth, or the mother's hospitalization if she is a Member, whichever is later; or
- A newly adopted child's (including a child placed with you for adoption) Membership will begin on the date when the adopting parent gains the legal right to control the child's health care if the Subscriber enrolls the child within 31 days of that date.
- The effective date of an enrollment resulting from a court or administrative order is the date of the court order.

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment form is received by the local Accounting or Benefits Office.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

In order to change from individual to two-party coverage and from two-party to family coverage, you will need to complete an enrollment form at the local Accounting or Benefits Office (or enroll electronically) within the PIE following the event (such as marriage, birth).

Notice to new enrollees about continuity of care

If you are currently receiving Services from a non-Plan Provider for an acute medical condition or an acute, serious, or chronic psychiatric condition and your enrollment with us will end coverage of the provider's Services, you may be eligible for temporary coverage of that non-Plan Provider's Services while your care is being transferred to us.

To qualify for this temporary coverage, all of the following criteria must be true:

- Your Health Plan coverage is in effect;
- You request this continuing coverage no later than 30 days from the start of your effective date of coverage by calling our Member Service Call Center;
- You are receiving Services during a current episode of care for an acute medical condition or an acute, serious, or chronic psychiatric condition from a non-Plan Provider on the effective date of your Health Plan coverage;
- When you chose Health Plan, you were not offered other coverage that included an out-of-network option that would have covered the Services of your current non-Plan Provider;
- You did not have the option to continue with your previous Health

Plan or to choose a Plan that covers the Services of your current non-Plan Provider;

- The non-Plan Provider agrees in writing to our standard contractual terms and conditions, including conditions pertaining to payment and providing Services within our Service Area;
- The Services to be provided to you by the non-Plan Provider are Medically Necessary and would be covered Services under the terms of your Health Plan coverage, if provided by a Plan Provider; and
- Medical Group authorizes the care by your non-Plan Provider because Plan Providers are unable to maintain the continuity of your care.

To request this coverage or a copy of our coverage policy, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

Dues

Your Group is responsible for paying Dues. If you are responsible for any contribution of the Dues, the University will tell you the amount and how to pay the University (through payroll deduction, for example).

Copayments and Coinsurance

You may be required to pay Copayments for some Services. These are listed in the "Benefits" section.

Copayments or Coinsurance are due when you receive the Service, but for items ordered in advance, you pay the Copayment or Coinsurance in effect on the order date (though we will not cover the item unless you still have coverage for it on the date you receive it). In some cases, we may agree to bill you for your Copayment or Coinsurance. If we agree to bill you, we will increase the amount by $13.50 and mail you a bill for the entire amount.

Annual Out-Of-Pocket Maximum

There is a limit to the total amount of Copayments and Coinsurance you must pay under this *DF/EOC* in a calendar year for the covered Services listed below. The limit is $1,500 (for a Member) or $3,000 (for an entire Family Unit). When you pay a Copayment or Coinsurance for these Services, ask for and keep the receipt. When the receipts add up to the annual Out-of-Pocket Maximum, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** (to find out where to bring your receipts. When you bring them in, we will give you a document to show that you do not have to pay any more Copayments or Coinsurance for these Services through the end of the calendar year.

Only the Copayments and Coinsurance you pay for these Services apply toward the Annual Out-of-Pocket Maximum:

- Ambulance Services;
- Amino acid–modified products used to treat congenital errors of amino acid metabolism;
- Diabetic testing supplies and equipment and insulin-administration devices;
- Home health care;
- Hospice care;
- Hospital care, including mental health inpatient care;

- Emergency Department visits;
- Imaging, laboratory, and special procedures;
- Office visits (including professional Services such as dialysis treatment, health education, and physical, occupational, and speech therapy);
- Outpatient surgery;
- Podiatric devices to prevent or treat diabetes-related complications;
- Prostheses and lymphedema wraps needed after a Medically Necessary mastectomy; and
- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx.

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 following sections about:

- Emergency Care, Out-of-Area Urgent Care, and, Post-stabilization Care received from non-Plan Providers, in the "Emergency, Urgent, and Routine Care" section;
- "Getting a referral" in this "How to Obtain Services" section; and
- "Our Visiting Member Program" in this "How to Obtain Services" 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, nurses, laboratory, and pharmacy Services, and other benefits described in the "Benefits" section.

Using your identification card

Each Member's Health Plan ID card has a Medical Record Number on it, which is useful when you call for advice, make an appointment, or go to a provider for covered care. Your Medical Record Number is used to identify your medical records and Membership information. Your Medical Record Number should never change. Please let us know if we ever inadvertently issue you more than one Medical Record Number, or if you need to replace your ID card, by calling our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

Your ID card is for identification only. To receive covered Services, you must be a current Health Plan 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.

Your primary care Plan Physician

Your primary care Plan Physician plays an important role in coordinating your medical care needs, including hospital stays and referrals to specialists. We encourage you to choose a primary care Plan Physician. You may select a primary care Plan Physician from any of our available Plan Physicians who practice in these specialties: internal medicine, obstetrics/gynecology, family practice, and pediatrics. You can also select a new primary care Plan Physician for any reason from any of our available Plan Physicians. To learn how to select a primary care Plan Physician, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

■ Special note about Coachella Valley and western Ventura County

Subscribers residing in Coachella Valley and western Ventura County are required to select a primary care Plan Physician (Affiliated Physician) for themselves and each covered Dependent. In these areas, Plan Providers (except for Plan Pharmacies that are owned and operated by Kaiser Permanente) are referred to as "Affiliated Providers," for example "Affiliated Physicians" and

"Affiliated Hospitals." Please refer to our "Service Area" section of "Section Three, General Information for All Members" for the ZIP codes that are in these two areas.

Your primary care Affiliated Physician will provide or arrange your care in these areas, including Services from other Affiliated Providers, such as specialty Affiliated Physicians. **For Services from Affiliated Providers to be covered, your primary care Affiliated Physician must prescribe the care or authorize the referral,** except for annual mammograms and visits to your obstetrics/gynecology Affiliated Physician, which you can get directly without a referral from your primary care Affiliated Physician. Also, you may receive care from Plan Providers outside of Coachella Valley and western Ventura County without a referral from your primary care Affiliated Physician (although some care requires a referral from a primary care Plan Physician, who need not be an Affiliated Physician; for more details see "Referrals to Plan Providers" in this "How to Obtain Services" section).

We will send the Subscriber a letter explaining how to select a primary care Affiliated Physician. If the Subscriber does not select a primary care Affiliated Physician, we will assign one. Dependents may select a different primary care Affiliated Physician from the Subscriber's by calling our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.** You may change your primary care Affiliated Physician once a month.

If you need care before we have confirmed your primary care Affiliated Physician, please call our Member Service Call Center for assistance. To learn about Affiliated Providers, please refer to *Your Guidebook*. You can get a copy of these directories by calling our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

If the Subscriber in your Family Unit does not live in Coachella Valley or western Ventura County, you may receive covered care from Affiliated Providers in these areas even if you haven't chosen a primary care Affiliated Physician.

Getting a referral

■ Referrals to Plan Providers

Primary Care plan Physicians provide primary medical, pediatric, obstetrics, and gynecology care. Plan specialists provide specialty care in areas such as surgery, orthopedics, cardiology, oncology, urology, and dermatology. A Plan Physician will refer you to a Plan specialist when appropriate. However, you do not need a referral to receive primary care from Plan Physicians in the following areas: internal medicine, obstetrics, gynecology, family planning, family practice, pediatrics, optometry, psychiatry, and chemical dependency. Please check *Your Guidebook* to see if your facility has other departments that do not require a referral. Also, please refer to "Special note about Coachella Valley and western Ventura County" in this "How to Obtain Services" section for additional requirements that apply when a Subscriber lives in these areas.

Medical Group authorization procedure for certain referrals

The following Services require prior authorization by Medical Group for the Services to be covered:

- **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 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 but not available from a Plan Provider.
- **Bariatric surgery.** If your Plan Physician makes a written referral for bariatric surgery, Medical Group's Regional bariatric medical director or his or her designee will authorize the Service if he or she determines that it is Medically Necessary in accord with Medical Group's bariatric surgery referral guidelines.
- **Durable medical equipment (DME).** If your Plan Physician prescribes DME, he or she will submit a written referral to the Plan Hospital's DME Coordinator, who will authorize the DME if he or she determines that your DME 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 DME formulary guidelines, then the DME Coordinator will contact the Plan Physician for additional information about the request. If the request still doesn't appear to meet our DME formulary guidelines, the request will be submitted to 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 DME formulary, please refer to "Durable medical equipment (DME)" in the "Benefits" 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 the item is listed on our 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 about the request. If the request still doesn't appear to meet our soft goods formulary guidelines, the request will be submitted to 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" section.
- **Transplants.** If your Plan Physician makes a written referral for a transplant, 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, Medical Group will refer you to physician(s) at a transplant center, and Medical Group will authorize the Services if the transplant center's

physician(s) determine that they are Medically Necessary.

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

The Copayments and Coinsurance for these referral Services are the same as those required for Services provided by a Plan Provider as described in the "Copayments and Coinsurance" section.

Medical Group's decision time frames. The applicable Medical Group designee will make the authorization decision within the time frame appropriate for your condition, but no later than five business days after receiving all 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 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, tests, or specialist that is needed and the date 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 Medical Group does not authorize all of the Services, you will be sent 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 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.

More information. This description is only a brief summary of the authorization procedure. For more information about 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 Medical Group), please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.** Please refer to the "Emergency, Urgent, and Routine Care" section for authorization requirements that apply to Post-stabilization Care. Also, please refer to "Your primary care Plan Physician" in this "How to Obtain Services" section for the authorization requirements that apply when a Subscriber lives in Coachella Valley or western Ventura County.

Second opinions

If you request a second opinion, it will be provided to you by an appropriately qualified health care professional. An appropriately qualified medical professional is a physician who is acting within his or her scope of practice and who possesses the clinical background related to the illness or condition associated with the request for a second medical opinion. If you want a second opinion, some examples of when a

second opinion is Medically Necessary are:

- If you are unsure about whether a procedure that has been recommended by your Plan Physician 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; or
- You have concerns about the diagnosis or plan of care.

You can either ask your Plan Physician to help you arrange for a second medical opinion, or you can make an appointment with another Plan Provider. If Medical Group determines that there isn't a Plan Provider who is an appropriately qualified medical professional for your condition, Medical Group will authorize a referral to a non-Plan Provider for a Medically Necessary second opinion. The Copayments and Coinsurance for these referral Services are the same as those required for Services provided by a Plan Provider as described in the "Copayments and Coinsurance" section.

If you have any questions, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

Contracts with Plan Providers

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, including salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Providers are paid to provide or arrange medical and hospital care for Members, please ask your Plan Physician or call our Member Service Call Center Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of noncovered Services or of Services you obtain from 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 so notify the Subscriber.

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

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

The Services must otherwise be covered under this *DF/EOC.* Also, the terminated provider must agree in writing to our contractual terms and conditions and comply with them for Services to be covered by Medical Group. The Copayments and Coinsurance for the Services of a terminated provider are the same as those required for Services provided by a Plan Provider as described in the "Copayments and Coinsurance" section.

If you would like more information about this provision, or to make a request, please call our Member Service Call Center.

Our Visiting Member Program

If you visit the service area of another Region temporarily (not more than 90 days), you can receive certain Services from designated providers in that area. Coverage for these Services may differ from that in our Service Area, and is governed by our program for visiting members. This program does not cover certain Services, such as transplant or infertility Services. Also, except for covered Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care, your right to receive covered Services in the visited service area ends after 90 days unless you receive prior written authorization from us to continue receiving covered Services in the visited service area.

Please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week,** for more information about our Visiting Member Program, including facility locations in other service areas. The service areas and facilities where you may obtain visiting member Services may change at any time.

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 primary care 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.

Most 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 Call Center representatives are available to assist you. Please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.** For your convenience, you can also contact us through the Member section of our Web site at *www.members.kp.org.*

Also, Member Service representatives at our Plan Facilities and Member Service Call 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 "Requests for Payment or Services" or with any issues in the "Dispute Resolution" section.

Plan Facilities

At most of our Plan Facilities, you can usually receive all the covered Services you need, including specialized 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.

■ Plan Hospitals and Plan Medical Offices

The following is a list of Plan Hospitals and most Plan Medical Offices in our Northern and Southern California Regions. Additional Plan Medical Offices are listed in *Your Guidebook*. 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 *DF/EOC* issued after that date. If we terminate a contract with a Plan Hospital, we will notify Subscribers who live in the hospital's area. If you have any questions about the current locations of Plan Facilities, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

■ Plan Hospitals and Medical Centers (Plan Hospitals and Medical Offices)

All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week.

- Emergency Care is 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.
- 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).

Northern California Region:

City	Street Address
Fremont	Medical Center: 39400 Paseo Padre Parkway
Fresno	Medical Center: 7300 North Fresno Street
Hayward	Medical Center: 27400 Hesperian Boulevard
Oakland	Medical Center: 280 West MacArthur Boulevard
Redwood City	Medical Center: 1150 Veterans Boulevard
Richmond	Medical Center: 901 Nevin Avenue
Roseville	Medical Center: 1600 Eureka Road Plan Medical Offices: 1001 Riverside Avenue
Sacramento	Medical Center: 2025 Morse Avenue Medical Center: 6600 Bruceville Road Additional Plan Medical Offices: 2345 Fair Oaks Boulevard 1650 Response Road
San Francisco	Medical Center: 2425 Geary Boulevard
San Jose	Medical Center: 250 Hospital Parkway (Santa Teresa Medical Center)
San Rafael	Medical Center: 99 Montecillo Road Plan Medical Office: 1540 Fifth Avenue
Santa Clara	Medical Center: 900 Kiely Boulevard Plan Medical Offices: 1333 Lawrence Expressway
Santa Rosa	Medical Center: 401 Bicentennial Way
South San Francisco	Medical Center: 1200 El Camino Real
Stockton	Plan Hospital: 525 West Acacia Street (Dameron Hospital) Plan Medical Office: 7373 West Lane
Vallejo	Medical Center: 975 Sereno Drive
Walnut Creek	Medical Center: 1425 South Main Street Plan Medical Offices: 320 Lennon Lane Emergency Care is also available at Mount Diablo Medical Center: at 2540 East Street Concord, CA, which is a Plan Hospital only for Emergency Care

■ Plan Medical Offices in other cities

City	Street Address
Alameda	2417 Central Avenue
Antioch	3400 Delta Fair Boulevard 5601 Deer Valley Road
Campbell	220 East Hacienda Avenue
Clovis	2071 Herndon Avenue
Daly City	395 Hickey Boulevard
Davis	1955 Cowell Boulevard

City	Street Address
Elk Grove	9201 Big Horn Boulevard
Fairfield	1550 Gateway Boulevard
Folsom	2155 Iron Point Road
Gilroy	7520 Arroyo Circle
Livermore	3000 Las Positas Road
Manteca	1721 West Yosemite Avenue
Martinez	200 Muir Road
Milpitas	770 East Calaveras Boulevard
Modesto	4125 Bangs Avenue
Mountain View	555 Castro Street
Napa	3285 Claremont Way
Novato	97 San Marin Drive
Oakhurst	40595 WestLake Drive
Petaluma	3900 Lakeville Highway
Pleasanton	7601 Stoneridge Drive
Rancho Cordova	10725 International Drive
Rohnert Park	5900 State Farm Drive
San Bruno	901 El Camino Real
Selma	2651 Highland Avenue
Union City	3553 Whipple Road
Vacaville	3700 Vaca Valley Parkway

■ Locations in Stanislaus County

City	Street Address
Stanislaus County	Plan Hospital: 825 Delbon Avenue, Turlock (Emanuel Medical Center) Plan Medical Offices: 4125 Bangs Avenue, Modesto (Please refer to *Your Guidebook* for other Plan Providers in Stanislaus county)

Southern California Region:

City	Street Address
Anaheim	Medical Center: 441 North Lakeview Avenue Medical Center: 3033 West Orange Avenue (west Anaheim) Additional Plan Medical Offices: 1188 North Euclid Street 411 North Lakeview Avenue

City	Street Address
Bakersfield	Plan Hospital: 420 34th Street (Memorial Hospital) Plan Hospital: 2215 Truxtun Avenue (Mercy Hospital) Plan Hospital: 300 Old River Road (Mercy Southwest Hospital) Plan Medical Offices: 3700 Mall View Road 8800 Ming Avenue 3501 Stockdale Highway 1200 Discovery Drive
Baldwin Park	Medical Center: 1011 Baldwin Park Boulevard
Bellflower	Medical Center: 9400 East Rosecrans Avenue
Escondido	Plan Hospital: 555 East Valley Parkway (Palomar) Plan Medical Office: 732 North Broadway Street
Fontana	Medical Center: 9961 Sierra Avenue
Harbor City	Medical Center: 25825 South Vermont Avenue
Irvine	Plan Hospital: 16200 Sand Canyon Avenue (Irvine Regional Hospital) Plan Medical Office: 6 Willard Street
Lancaster	Plan Hospital: 1600 West Avenue J (Antelope Valley Hospital) Plan Hospital: 43830 North 10th Street West (Lancaster Community Hospital) Plan Medical Office: 43112 North 15th Street West
Los Angeles	Medical Center: 1526 North Edgemont Street Medical Center: 6041 Cadillac Avenue (west LA) Additional Plan Medical Offices: 5220 Telford Street (east LA) 5119 Pomona Boulevard (east LA) 12001 West Washington Boulevard (Culver Marina Medical Offices)
Panorama City	Medical Center: 13652 Cantara Street
Riverside	Medical Center: 10800 Magnolia Avenue
San Diego	Medical Center: 4647 Zion Avenue Additional Plan Medical Offices: 7060 Clairemont Mesa Boulevard 4650 Palm Avenue 3250 Fordham Street 3420 Kenyon Street 3250 Wing Street 11939 Rancho Bernardo Road 4405 Vandever Avenue
Woodland Hills	Medical Center: 5601 De Soto Avenue

■ Plan Medical Offices in other cities

City	Street Address
Aliso Viejo	24502 Pacific Park Drive

City	Street Address
Bonita	3955 Bonita Road
Brea	1900 East Lambert Road
Carlsbad	6860 Avenida Encinas
Chino	11911 Central Avenue
Claremont	250 West San Jose Street
Colton	789 South Cooley Drive
Corona	2055 Kellogg Avenue
Cudahy	7825 Atlantic Avenue
Culver City	5620 Mesmer Avenue
Downey	9449 East Imperial Highway
El Cajon	1630 East Main Street 250 Travelodge Drive
Garden Grove	12100 Euclid Street
Gardena	15446 South Western Avenue
Glendale	444 West Glenoaks Boulevard
Huntington Beach	18081 Beach Boulevard
Inglewood	110 North La Brea Avenue
La Mesa	8080 Parkway Drive and 3875 Avocado Boulevard
La Palma	5 Centerpointe Drive
Long Beach	3900 East Pacific Coast Highway
Mission Viejo	23781 Maquina Avenue
Montebello	1550 Town Center Drive
Moreno Valley	12815 Heacock Street
Ontario	1025 West “I” Street
Pasadena	450 North Lake Avenue
Rancho Cucamonga	10850 Arrow Route
Redlands	25828 Redlands Boulevard
San Bernardino	1717 Date Place
San Dimas	1255 West Arrow Highway
San Juan Capistrano	30400 Camino Capistrano
Santa Ana	3401 South Harbor Boulevard 1900 East 4th Street
Santa Clarita	27107 Tourney Road
Simi Valley	3900 Alamo Street
Thousand Oaks	365 East Hillcrest Drive and 145 Hodencamp Road
Victorville	14011 Park Avenue
Vista	780 Shadowridge Drive
West Covina	1249 Sunset Avenue
Whittier	12470 Whittier Boulevard
Wildomar	36450 Inland Valley Drive
Yorba Linda	22550 East Savi Ranch Parkway

Affiliated Plan Hospitals

Western Ventura County	• St. John's Regional Medical Center at 1600 North Rose Avenue, Oxnard, CA • Community Memorial Hospital of San Buenaventura at 147 North Brent Street, Ventura, CA
Coachella Valley	• Desert Regional Medical Center at 1150 North Indian Canyon Drive, Palm Springs, CA • Eisenhower Medical Center at 39000 Bob Hope Drive, Rancho Mirage, CA • Hi-Desert Medical Center at 6601 White Feather Road, Joshua Tree, CA • John F. Kennedy Memorial Hospital at 47111 Monroe Street, Indio, CA

For information about receiving care in these areas, see the "Special note about Coachella Valley and western Ventura County" in the "How to Obtain Services" section. Also, please refer to *Your Guidebook* for these areas for other Plan Providers, including Affiliated Plan Physicians and Pharmacies.

Your Guidebook

Plan Medical Offices and Plan Hospitals for your area are also 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, and includes a detailed telephone directory for appointments and advice. *Your Guidebook* provides other important information, such as your Member rights and responsibilities. It is subject to change and periodically updated. You can get a copy by calling our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week,** or log on to *www.members.kp.org.*

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 Call 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.

Emergency, Urgent, and Routine Care

This section explains how to obtain covered Emergency Care, urgent care, Post-stabilization Care, and routine care. It also describes how our advice nurses can help assess nonemergency medical symptoms.

Emergency Care

If you have an Emergency Medical Condition, call 911 or go to the nearest hospital. When you have an Emergency Medical Condition, we cover Emergency Care from Plan Providers and non-Plan Providers anywhere in the world. An Emergency Medical Condition is:

- A medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in any of the following:
  - serious jeopardy to your health;
  - serious impairment to your bodily functions; or
  - serious dysfunction of any bodily organ or part.
- "Active labor," which means a labor when there is inadequate time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the Member or unborn child.

Note: Emergency Care is available at Plan Hospital Emergency Departments listed in *Your Guidebook*. For ease and continuity of care, we encourage you to go to a Plan Hospital Emergency Department, but only if it is reasonable to do so, considering your condition or symptoms. Please refer to *Your Guidebook* for Plan Hospital Emergency Department locations in your area.

Urgent care

When you are sick or injured, you may have an urgent care need. 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 nurse telephone number at a Plan Facility. Please refer to *Your Guidebook* for advice nurse and Plan Facility telephone numbers.

Out-of-Area Urgent Care

If you are temporarily outside our Service Area and have an urgent care need due to an unforeseen illness or injury, we cover the Medically Necessary Services you receive from a non-Plan Provider if we find that the Services were necessary to prevent serious deterioration of your health and they could not be delayed until you returned to our Service Area.

Post-stabilization and follow-up care

Post-stabilization Care is the Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable, or after you obtain covered Out-of-Area Urgent Care. We cover Post-stabilization Care only if a Plan Provider provides it or if we authorize your receiving the care from a non-Plan Provider.

To request authorization to receive Post-stabilization Care from a non-Plan Provider, you must call us toll free at

1-800-225-8883 *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 your Post-stabilization 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 Provider (or other designated 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 transportation) we have authorized since we do not cover unauthorized Post-stabilization Care provided by non-Plan Providers.

Follow-up care. We do not cover follow-up care provided by non-Plan Providers unless it is covered Emergency Care, Out-of-Area Urgent Care, or Post-stabilization Care described in this "Emergency, Urgent, and Routine Care" section.

Call us!

You must call us toll free at **1-800-225-8883** (or the notification telephone number on your ID card) to request authorization for Post-stabilization Care *before* you obtain the care from a non-Plan Provider if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible). Also, please call us any time you are admitted to a non-Plan Hospital.

We understand that extraordinary circumstances can delay your ability to call us, for example, if you are unconscious or a young child without a parent or guardian present. 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 you're Clinically Stable 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.

Payment and reimbursement

If you receive Emergency Care, Out-of-Area Urgent Care, or Post-stabilization Care from a non-Plan Provider, the provider may agree to bill for the Services or may require that you pay for the Services at that time. In either case, to request payment or reimbursement, you must file a claim as described under "Non-Plan Emergency Care, Out-of-Area Urgent Care, or Post-stabilization Care" in the "Requests for Payment or Services" section.

We will reduce any payment we make by applicable Copayments or Coinsurance, which are the same ones required for Services provided by a Plan Provider as described in the "Copayments and Coinsurance" section.

Routine care

If you need to make a routine care appointment, please refer to *Your Guidebook* for appointment telephone numbers, or log on to *www.members.kp.org* to request an appointment online. Routine appointments are for medical needs that aren't urgent (such as routine check-ups and school physicals). Try to make your

routine care appointments as far in advance as possible.

Our advice nurses

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. Whether you are calling for advice or to make an appointment, you can speak to an advice nurse. They can often resolve a minor concern or advise you about what to do next, including making a same-day urgent care appointment for you if it's medically appropriate. To reach an advice nurse, please refer to *Your Guidebook* for the telephone numbers.

Benefits

The Services described in this Traditional Plan "Benefits" section are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary.
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except where specifically noted to the contrary in the following sections about:
  - Our Visiting Member Program, in the "How to Obtain Services" section; and
  - Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care received from non-Plan Providers, in the "Emergency, Urgent, and Routine Care" section.
- You receive the Services from Plan Providers inside our Service Area, except where specifically noted to the contrary in the following sections about:
  - Getting a referral, in the "How to Obtain Services" section;
  - Our Visiting Member Program, in the "How to Obtain Services" section; and
  - Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care received from non-Plan Providers, in the "Emergency, Urgent, and Routine Care" section.

Exclusions and limitations that apply only to a particular benefit are described in this "Benefits" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. Also, please refer to:

- The "Emergency, Urgent, and Routine Care" section for information about how to obtain Emergency Care, urgent care, Post-stabilization Care, and routine care;
- The "Copayments and Coinsurance" section for the amounts you must pay for covered Services described in this "Benefits" section; and
- *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.

Hospital inpatient care

We cover the following inpatient Services in a Plan Hospital when the Services are generally and customarily provided by acute care general hospitals in our Service Area. There is a charge of **$250 per hospital inpatient admission.**

- Room and board, including a private room, if Medically Necessary;
- Specialized care and critical care units;
- General and special prescribed nursing care;
- Operating and recovery rooms;
- Plan Physicians' and surgeons' Services, including consultation and treatment by specialists;
- Anesthesia;
- Medical supplies;

- Blood, blood products, and their administration;
- Obstetrical care and delivery (including cesarean section);
- **Note:** If you are discharged within 48 hours after delivery (or 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.
- Physical, occupational, and speech therapy (including treatment in our organized, multidisciplinary rehabilitation program in a licensed acute rehabilitation facility);
- Respiratory therapy; and
- Medical social Services and discharge Planning.

The following types of inpatient Services are covered only as described under these headings in this Traditional Plan "Benefits" section:

- "Chemical dependency Services"
- "Dental Services for radiation treatment and dental anesthesia"
- "Dialysis care"
- "Drugs, supplies, and supplements"
- "Durable medical equipment (DME)"
- "Hospice care"
- "Imaging, laboratory, and special procedures"
- "Infertility Services"
- "Mental health Services"
- "Ostomy and urological supplies"
- "Prosthetic and orthotic devices"
- "Reconstructive surgery"
- "Services associated with Clinical Trials"
- "Skilled Nursing Facility care"
- "Transplant Services"

Outpatient care

We cover the following outpatient care for preventive medicine, diagnosis, and treatment at **$10 per visit:**

- Primary care visits for internal medicine, gynecology (cervical cancer screening tests and mammograms are included with the office visit Copayment or Coinsurance), family practice, and pediatrics;
- Specialty care visits (refer to "Referrals to Plan Providers" in the "How to Obtain Services" section for information about referrals to Plan specialists);
- Allergy testing;
- Outpatient surgery;
- Respiratory therapy visits;
- Preventive health screenings;
- Physical, occupational, and speech therapy (including treatment in our organized, multidisciplinary rehabilitation day treatment program); and
- Post-transplant care.

We cover the following outpatient care at **$5 per visit:**

- Allergy injections.

We cover the following outpatient care at **no charge:**

- Blood, blood products, and their administration;
- Medical social Services;

- After confirmation of pregnancy, all Obstetrical Department prenatal visits and the first postpartum visit;
- Scheduled well-child preventive care visits (age 23 months or younger); and
- House calls within our Service Area when care can best be provided in your home as determined by a Plan Physician.

Note: Emergency Department visits (please refer to the "Emergency, Urgent, and Routine Care" section for information about Emergency Care and urgent care).

Emergency Care: $50 per visit*

*Waived if admitted directly to the hospital.

Out-of-Area Urgent Care:

$50 per visit (when seen in the emergency room at a non-Plan Facility)

$10 per visit if seen in a physician's office

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

- "Chemical dependency Services"
- "Dental Services for radiation treatment and dental anesthesia"
- "Dialysis care"
- "Drugs, supplies, and supplements"
- "Durable medical equipment (DME)"
- "Family Planning Services"
- "Health education"
- "Hearing Services"
- "Home health care"
- "Hospice care"
- "Imaging, laboratory, and special procedures"
- "Infertility Services"
- "Mental health Services"
- "Ostomy and urological supplies"
- "Prosthetic and orthotic devices"
- "Reconstructive surgery"
- "Services associated with Clinical Trials"
- "Transplant Services"
- "Vision Services"

Ambulance Services

Emergency

When you have an Emergency Medical Condition, we cover emergency Services of a licensed ambulance at **no charge.** We cover emergency ambulance Services that are not ordered by us only if one of the following is true:

- Your treating physician determines that you must be transported to another facility when you are not Clinically Stable because the care you need is not available at the treating facility; or
- You are not already being treated, and you reasonably believe that your condition requires ambulance transportation.

Nonemergency

We cover nonemergency ambulance Services at **no charge** if a Plan Physician determines your condition requires the use of Services that only a licensed ambulance can provide and the use of other means of transportation would endanger your health.

Ambulance Services exclusion

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

Chemical dependency Services

Inpatient detoxification

We cover hospitalization in a Plan Hospital only for medical management of withdrawal symptoms, including dependency recovery Services, education, and counseling. There is a charge of **$250 per hospital inpatient admission.**

Outpatient

We cover the following Services for treatment of chemical dependency:

- Day treatment programs;
- Intensive outpatient programs;
- Medical treatment for withdrawal symptoms; and
- Counseling for chemical dependency.

  $10 per individual therapy visit

  $5 per group therapy visit

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

Transitional residential recovery Services

We cover up to 60 days per calendar year of chemical dependency treatment in a nonmedical transitional residency recovery setting approved in writing by Medical Group at **$100 per admission;** no more than 120 days of covered care is provided in any five-consecutive-calendar-year period. These settings provide counseling and support Services in a structured environment.

Chemical dependency Services exclusions

- Services in a specialized facility for alcoholism, drug abuse, or drug addiction, except as described above.

Dental Services for radiation treatment

Dental Services for radiation treatment

We cover evaluation, extraction, dental X-rays, and fluoride treatment, if a Plan Physician refers you to a dentist (as described in “Medical Group authorization procedure for certain referrals” under “Getting a referral” in the “How to Obtain Services” section”) to prepare your jaw for radiation treatment of cancer.

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 is true:

- You are under age seven, 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; and
- 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.

Inpatient care: $250 per admission

Outpatient care: $10 per visit

Dialysis care

If the following criteria are met, we cover dialysis Services related to acute renal failure and end-stage renal disease:

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

Inpatient care: $250 per admission

Outpatient care: $10 per visit

Dialysis treatment: $10 per visit

After the referral to a dialysis facility, we cover equipment, training, and medical supplies required for home dialysis at **no charge.**

Drugs, supplies, and supplements

We cover drugs, supplies, and supplements specified in this section when prescribed by a Plan Physician (except as otherwise described under "Outpatient drugs, supplies, and supplements") and in accord with our drug formulary guidelines.

You must obtain covered drugs, supplies, and supplements from a Plan Pharmacy. Please refer to *Your Guidebook* for the location of Plan Pharmacies in your area. You may be able to order refills through our Web site at *www.members.kp.org.* A Plan Pharmacy or *Your Guidebook* can give you more information about obtaining refills (for example most Plan Pharmacies offer refills by mail, whereas a few Plan Pharmacies don't dispense covered refills).

Note: Durable medical equipment (DME) used to administer drugs is not covered under this section (instead, refer to the "Durable medical equipment (DME)" section).

■ Administered drugs and self-administered IV drugs

Administered drugs, supplies, and supplements. We cover the following at **no charge** during a covered stay in a Plan Hospital or Skilled Nursing Facility, or if they require administration or observation by medical personnel and are administered to you in a Plan Medical Office or during home visits:

- Drugs, injectables, internally implanted time-release contraceptives, intrauterine devices (IUDs), emergency contraceptive pills, radioactive materials used for therapeutic purposes, vaccines and immunizations approved for use by the federal Food and Drug Administration (FDA), and allergy test and treatment materials.

Self-administered IV drugs, supplies, and supplements. We cover certain drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as IV or intraspinal-infusion) at **no charge.** We also cover the supplies and equipment required for their administration. Injectable drugs, insulin, and drugs for the treatment of

infertility are not covered under this paragraph (instead, refer to the "Outpatient drugs, supplies, and supplements" paragraph below).

■ Diabetes urine-testing supplies and certain insulin administration devices

We cover the following diabetes urine-testing supplies:

- Ketone test strips and sugar or acetone test tablets or tapes at **no charge.**

Note: Diabetes blood-testing equipment and their supplies are not covered under this "Drugs, supplies, and supplements" section (instead, refer to the "Durable medical equipment (DME)" section).

We cover the following insulin-administration devices:

- Disposable needles and syringes, pen delivery devices, and visual aids required to ensure proper dosage (except eyewear) at **$10 per prescription for up to a 100-day supply.**

Note: Insulin pumps and their supplies are not covered under this "Drugs, supplies, and supplements" section (instead, refer to the "Durable medical equipment (DME)" section).

■ Outpatient drugs, supplies, and supplements

We cover the following drugs, supplies, and supplements when prescribed by a Plan Physician or dentist. (Drugs, supplies, and supplements prescribed by dentists are not covered if a Plan Physician determines that they are not Medically Necessary.) We cover at **$10 generic/$20 brand name per prescription for up to a 100-day supply:**

- 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.
- Smoking-cessation drugs are covered if you participate in a Plan-approved behavior intervention program.
- Diaphragms, cervical caps, and oral contraceptives.
- Disposable needles and syringes needed for injecting covered drugs.

Note: You will pay the Copayment or Charges, whichever is less.

We cover the following at **50 percent Coinsurance:**

- Drugs for diagnosis and treatment of infertility.

We cover drugs for the treatment of sexual dysfunction disorders as follows:

- Episodic drugs, as prescribed by a Plan Physician, will be provided up to a maximum of 27 doses in any 100-day period at **50 percent Coinsurance.**

Additional prescribed doses that exceed the dose maximum during the same 100 days will be dispensed at Charges.

- Maintenance (nonepisodic) drugs, as prescribed by a Plan Physician, that require doses at regulated intervals will be provided at **50 percent Coinsurance for up to a 100-day supply.**

■ 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 comprised 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 information about whether a particular drug is included in our drug formulary, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.** The presence of a drug on our drug formulary does not necessarily mean that your Plan Physician will prescribe it for a particular condition.

Our drug formulary guidelines allow you to obtain nonformulary prescription drugs (those not listed on our drug formulary for your condition) if 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 Plan-approved behavioral intervention program for specific conditions, and you may be required to pay for the program.

■ Drugs, supplies, and supplements exclusions

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

Note: If this *DF/EOC* is amended to exclude a drug that we have been covering and providing to you under this *DF/EOC*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the FDA. You must pay a **50 percent Coinsurance.**

Durable medical equipment (DME)

We cover durable medical equipment (DME) at **no charge** in accord with our DME formulary guidelines. Coverage is limited to the standard item of equipment that adequately meets your medical needs.

DME at a Plan Hospital or Skilled Nursing Facility

We cover equipment, including oxygen used during a covered stay in a Plan Hospital or Skilled Nursing Facility, if Skilled Nursing Facilities ordinarily furnish the equipment.

DME for home use

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.

Inside our Service Area, we cover DME for use in your home (or another location used as your home inside our Service

Area). If you live outside our Service Area, we do not cover most DME for use in your home, but our DME formulary guidelines allow certain DME (such as crutches and canes) for use in your home to be picked up from Plan Facilities even if you live outside our Service Area. To find out whether we will cover a particular DME item even if you live outside our Service Area, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

We decide whether to rent or purchase the equipment, and we select the vendor. We will repair or replace the equipment, unless the repair or replacement is due to loss or misuse. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.

■ About our DME formulary

Our DME formulary includes the list of durable medical equipment that has been approved by our DME Formulary Review Committee for our Members. The DME formulary was developed by a multidisciplinary clinical and operational workgroup with review and input from Plan Physicians and medical professionals with DME expertise (for example physical, respiratory, and enterostomal therapists and home health). A multidisciplinary DME Formulary Review Committee is responsible for reviewing and revising the DME formulary. The DME formulary is periodically updated to keep pace with changes in medical technology and clinical practice. To find out whether a particular DME is included in our DME formulary, please call our Member Service Call Center.

Our formulary guidelines allow you to obtain nonformulary DME (those not listed on our DME formulary for your condition) if Medical Group determines that it is Medically Necessary as described in "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section.

Note: Diabetes urine-testing supplies and insulin-administration devices (except insulin pumps) are not covered under this "Durable medical equipment (DME)" section (instead, refer to the "Drugs, supplies, and supplements" section). This section does apply to the following diabetes blood testing equipment and insulin-administration devices:

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

■ Durable medical equipment exclusions

- Comfort, convenience, or luxury equipment or features;
- Exercise or hygiene equipment;
- Dental appliances;
- Nonmedical items such as sauna baths, whirlpools, or elevators;
- Modifications to your home or car;
- Electronic monitors of the heart or lungs, except infant apnea monitors; or
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their

supplies, such as blood glucose monitor test strips and lancets, and lancet devices).

Family planning Services

We cover:

- Family planning counseling, including preabortion and postabortion counseling, and information on birth control;
- Tubal ligations;
- Vasectomies; and
- Voluntary termination of pregnancy.

Inpatient Services: $250 per hospital inpatient admission

Outpatient visits: $10 per visit

Note: Contraceptive drugs and devices are not covered under this "Family planning Services" section (instead, refer to "Drugs, supplies, and supplements" in this "Benefits" section).

Health education

We cover a variety of health education programs to help you protect and improve your health, including programs for smoking cessation, stress management, and chronic conditions (such as diabetes and asthma). You can also participate in programs and classes that we don't cover, which may require that you pay a fee. For more information about our health education programs, please contact your local Health Education Department or call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week,** or log on to *www.members.kp.org*. *Your Guidebook* also includes information about our health education programs.

Individual office visit: $10 per visit

All other covered Services: No charge

Hearing Services

Hearing tests. We cover hearing tests to determine the need for hearing correction and to determine the most appropriate hearing aid at **$10 per visit.**

Hearing aid(s). We cover the following:

- A hearing aid (up to an allowance of **$1,000 per ear**) for each ear and a replacement hearing aid for each ear after 36 months when prescribed by a Plan Physician. The allowance can only be used at the initial point of sale. If you do not use all of your allowance at the initial point of sale, you cannot use it later. We will cover two hearing aids only if both are required to provide significant improvement that is not obtainable with only one hearing aid;
- Visits to verify that the hearing aid conforms to the prescription; and
- Visits for fitting, counseling, adjustment, cleaning, and inspection after the warranty is exhausted.

We select the provider or vendor that will furnish the covered device. Coverage is limited to the standard hearing aid that adequately meets your medical needs.

■ Hearing Services exclusions

- Replacement parts and batteries;
- Replacement of lost or broken hearing aids;
- Repair of hearing aids after the warranty period;
- Internally implanted hearing aids;

- Comfort, convenience, or luxury equipment or features; and
- Hearing aids prescribed or ordered before the effective date or after the termination date of your coverage.

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 **no charge** 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, or speech therapist;
- 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; and
- The Services are provided inside our Service Area.

The following types of Services are covered in the home only as described under these headings in this "Benefits" section:

- "Dialysis care"
- "Drugs, supplies, and supplements"
- "Durable medical equipment (DME)"
- "Ostomy and urological supplies"
- "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; and
- 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 Services listed below 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 (including a friend's or relative's home even if you live there temporarily) by a licensed hospice

agency approved by Medical Group; and

- 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 at **no charge,** 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 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 Call Center for the current list of these drugs.
- Durable medical equipment.
- Respite care, which is occasional short-term inpatient care limited to no more than five consecutive days at a time, when necessary to relieve your caregivers.
- 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; and
  - short-term inpatient care required at a level that cannot be provided at home.

Imaging, laboratory, and special procedures

We cover the following Services at **no charge** only when prescribed as part of care covered under other parts of this “Benefits” section (for example, diagnostic imaging and laboratory tests are covered for infertility only to the extent that infertility Services are covered under “Infertility Services”):

- Diagnostic and therapeutic imaging, such as X-rays, magnetic resonance imaging (MRI), computed tomography, and positron emission tomography;
- Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available;
- Special procedures such as electrocardiograms and electroencephalograms; and
- Ultraviolet light treatment.

We cover the following Services at **50 percent Coinsurance:**

- Laboratory and X-ray Services for infertility diagnosis and treatment.

Infertility Services

We cover the following Services at **50 percent Coinsurance:**

- Services for diagnosis and treatment of involuntary infertility.
- Artificial insemination (except for donor semen or eggs and Services related to their procurement and storage).

Note:

- Diagnostic procedures are not covered under this “Infertility Services” section (instead, refer to “Imaging, laboratory, and special procedures” in this “Benefits” section.
- Drugs related to the diagnosis and treatments of involuntary infertility are not covered under this “Infertility Services” section (instead, refer to “Drugs, supplies, and supplements” in this “Benefits” section).

Infertility Services exclusions

Services to reverse voluntary, surgically induced infertility are not covered.

Mental health Services

We cover mental health Services as specified below, except that any outpatient-visit and inpatient-day limits specified below do not apply to the following conditions:

- These severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.
- A Serious Emotional Disturbance (SED) of a child under 18, which means mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child’s age according to expected developmental norms, if the child also meets at least one of the following three criteria:
    - as a result of the mental disorder, 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 either (a) the child is at risk of removal from 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; or
    - 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.

For all other mental health conditions, we cover evaluation, crisis intervention, and treatment only when a Plan Physician or other Plan mental health

professional believes the condition will significantly improve with relatively short-term therapy.

Outpatient mental health Services

We cover:

- Diagnostic evaluation and psychiatric treatment;
- Individual and group therapy visits;
- Prescribed psychological testing; and
- Visits for the purpose of monitoring drug therapy.

Individual office visits: $10 per visit

Group therapy visits: $5 per visit

Inpatient psychiatric care

We cover short-term psychiatric hospitalization in a Plan Hospital, including Services of Plan Physicians and other Plan mental health professionals, when referred by your Plan Provider. There is a charge of **$250 per hospital inpatient admission.**

Hospital alternative Services

We cover treatment in a structured multidisciplinary program as an alternative to inpatient psychiatric care at **no charge.** Hospital alternative Services include partial hospitalization and treatment in an intensive outpatient psychiatric treatment program.

Note: Drugs, supplies, and supplements are not covered under this "Mental health Services" section (instead, refer to "Drugs, supplies, and supplements" in this "Benefits" section).

Ostomy and urological supplies

Inside our Service Area, we cover ostomy and urological supplies at **no charge** prescribed in accord with our soft goods formulary guidelines.

We select the vendor and coverage is limited to the standard item of equipment 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 Review Committee for our Members. Our Soft Goods Formulary Review Committee is responsible for reviewing and revising the soft goods formulary. The 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 Call 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 Medical Group determines that it is Medically Necessary as described in "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section.

■ Ostomy and urological supplies exclusions

Comfort, convenience, or luxury equipment or features.

Prosthetic and orthotic devices

We cover the devices listed below if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is not ill or

injured. Also, coverage is provided only in our Service Area and limited to the standard device that adequately meets your medical needs. We also cover enteral formula for Members who require tube feeding in accord with Medicare guidelines.

We select the provider or vendor that will furnish the covered device. 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 do not cover the device, we try to help you find facilities where you may obtain what you need at a reasonable price.

■ Internally implanted devices

We cover internal devices implanted during covered surgery, such as pacemakers and hip joints, that are approved by the federal Food and Drug Administration for general use at **no charge.**

■ External devices

We cover the following external prosthetics and orthotics at **no charge:**

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (including electronic voice-producing machines for Medicare Members only);
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres every 12 months;
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan podiatrist, physiatrist, or orthopedist;
- Compression burn garments and lymphedema wraps and garments; and
- 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 semirigid orthotic devices required to support or correct a defective body part; and
  - Special footwear for foot disfigurement due to disease, injury, or developmental disability.

■ Prosthetic and orthotic devices exclusions

- Eyeglasses and contact lenses;
- Hearing aids under this benefit (please see “Hearing Services” in this “Benefits” section);
- Dental appliances;
- Except as described above, nonrigid supplies such as elastic stockings and wigs;
- Comfort, convenience, or luxury equipment or features;
- Electronic voice-producing machines; and
- Shoes or arch supports, even if custom made, except footwear described above for diabetes-related complications and foot disfigurement.

Reconstructive surgery

We cover 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.

■ Mastectomies

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.

Inpatient Services: $250 per admission

Outpatient visits: $10 per visit

Outpatient surgery: $10 per procedure

Note: Prosthetics and orthotics are not covered under this “Reconstructive surgery” section (instead, refer to “Prosthetic and orthotic devices” in this “Benefits” section).

■ Reconstructive surgery exclusions

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance; and
- 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 recommends participation in the Clinical Trial after determining that it has a meaningful potential to benefit you (non-Plan Provider Services are covered in accord with “Medical Group authorization procedure for certain referrals” in the “How to Obtain Services” section);
- The Services would be covered under this *DF/EOC* if they were not provided in connection with a Clinical Trial;
- The Clinical Trial has a therapeutic intent, and its endpoints are not defined exclusively to test toxicity; and
- 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 Department of Veterans Administration.

■ 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; and

- Services associated with the provision of drugs or devices that have not been approved by the federal Food and Drug Administration.

Skilled Nursing Facility care

Inside our Service Area, we cover up to **100 days per calendar year** of skilled inpatient Services in a licensed Skilled Nursing Facility when prescribed by a Plan Physician. The skilled inpatient Services must be Medically Necessary, customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

We cover the following Services at **no charge:**

- Physician and nursing Services;
- Room and board;
- Medical social Services;
- Blood, blood products, and their administration;
- Medical supplies;
- Respiratory therapy; and
- Physical, occupational, and speech therapy.

Note:

- Drugs are not covered under this “Skilled Nursing Facility care” section (instead, refer to the “Drugs, supplies, and supplements” section).
- Durable medical equipment is not covered under this “Skilled Nursing Facility care” section (instead, refer to the “Durable medical equipment (DME)” section).
- Imaging, laboratory, and special procedures are not covered under this “Skilled Nursing Facility care” section (instead, refer to the “Imaging, laboratory, and special procedures” section).

Transplant Services

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

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

- If either 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, Hospitals, Medical Group, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone-marrow donor; and
- 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 Medical Group as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. Our criteria for donor Services are available by calling our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

Inpatient Services: $250 per admission

Outpatient visits: $10 per visit

Vision Services

We cover:

- Refraction exams to determine the need for vision correction and to provide a prescription for eyeglass lenses at **$10 per visit.**
- We do not cover eyeglasses or contact lenses. However, we do cover Medically Necessary contact lenses to treat aniridia (missing iris), up to two lenses per eye every 12 months when prescribed by a Plan Physician or Plan optometrist.

■ Vision Services exclusions

- Eyeglass lenses or frames;
- Contact lenses or contact lens examinations, fittings, or dispensing except as described above to treat aniridia; or
- Services related to eye surgery or orthokeratologic Services for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia), and astigmatism.

■ Eyeglasses and contact lenses following cataract surgery

For Medicare Part B Members who have assigned their benefits to Kaiser Permanente, we provide a **$150 allowance** for each affected eye to pay for eyeglass lenses, frames, contact lenses, and fitting and dispensing. The allowance applies to each affected eye following cataract surgery and is provided once per lifetime. Also, the allowance can only be used at the initial point of sale. If you do not use all of your allowance for one eye at the initial point of sale, you cannot use it later.

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The Services listed below are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under "Section One, Traditional Plan" of this *DF/EOC.* Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits" section.

- **Certain exams and Services.** Physical examinations and other Services:

1. Required for obtaining or maintaining employment or participation in employee programs, or
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.** All Services (other than artificial insemination described under "Infertility Services" in the "Benefits" section) related to conception by artificial means, such as ovum transplants; gamete intrafallopian transfer (GIFT); donor semen or 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 improve your appearance, except for Services covered under "Reconstructive surgery" in the "Benefits" section and prostheses needed after a mastectomy covered under "Prosthetic and orthotic devices" in the "Benefits" section.
- **Custodial care.** Custodial care means:
  1. Assistance with activities of daily living (example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine), or
  2. Care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.

This exclusion does not apply to Services covered under "Hospice care" in the "Benefits" section.

- **Dental care.** Dental care and dental X-rays, such as dental Services following accidental injury to teeth, dental appliances, dental implants, orthodontia, and dental Services resulting from medical treatment (such as surgery on the jawbone and radiation treatment), except for Services covered under "Dental Services for radiation treatment" and "Dental anesthesia" in the "Benefits" section.

- **Experimental or investigational Services.** A Service is experimental or investigational if we, in consultation with Medical Group, determine that:
  - 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); or
  - It requires government approval that has not been obtained when the Service is to be provided.

This exclusion does not apply to Services covered under "Services associated with Clinical Trials" in the "Benefits" 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.** Services for 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 "Hospice care" in the "Benefits" section.
- **Routine foot care Services.** Routine foot care Services that are not Medically Necessary.
- **Services related to a noncovered Service.** When a Service is not covered, all Services related to the noncovered Service are excluded, except that this exclusion does not apply to Services we would otherwise cover to treat complications of the noncovered Service.
- **Sexual reassignment surgery.**
- **Speech therapy.** Speech therapy Services to treat social, behavioral, or cognitive delays in speech or language development unless Medically Necessary.
- **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 to another person or persons who intend to raise the child. Please refer to "Surrogacy arrangements" in the "Reductions" section for information about your obligations to us in connection with a surrogacy arrangement, including your obligation to reimburse us for any Services we cover.
- **Travel and lodging expenses.** Travel and lodging expenses, except that in some situations if Medical Group refers you to a non-Plan Provider as described in "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section, we may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines. Our travel and lodging guidelines are available from our Member Service Call Center.

Limitations

We will do our best to provide or arrange for our Members' health care needs in the event of unusual circumstances that delay or render impractical the provision of Services

under this *DF/EOC*, such as 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 disputes. Under these extreme circumstances, if you have an Emergency Medical Condition, go to the nearest hospital as described under "Emergency Care" in the "Emergency, Urgent, and Routine Care" section, and we will provide coverage and reimbursement as described in that section.

Coordination of benefits (COB)

The Services covered under this *DF/EOC* are subject to coordination of benefits (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB rules of the California Department of Managed Health Care. Those rules are incorporated into this *DF/EOC*.

If both we and the other coverage cover the same Service, we and the other coverage will see that up to 100 percent of your covered medical expenses are paid for that Service. The COB 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 *DF/EOC* is secondary, we may be able to establish a Benefit Reserve Account for you. You may draw on the Benefit Reserve Account during the calendar year to pay for your out-of-pocket expenses for Services that are partially covered by either us or your other coverage. 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 COB, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

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.** You must pay us Charges for covered Services you receive for an injury or illness that is alleged to be caused by a third party's act or omission, except that you do not have to pay us more than you receive from or on behalf of the third party.

To the extent permitted 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 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 recovery 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:

Northern California Members:

Kaiser Permanente
Special Recovery Unit
COB/TPL
P.O. Box 2073
Oakland, CA 94604-9877

Southern California Members:

Kaiser Permanente
Special Recovery Unit-8553
Parsons East, Second Floor
P.O. Box 7017
Pasadena, CA 91109-9977

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 must not take any action prejudicial to our rights.

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 are entitled to 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 assert any independent lien rights they may have to recover their General Fees from 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 to which you are entitled under Medicare, except for Members whose Medicare benefits are secondary by law.
- **Surrogacy arrangements.** You must pay us the Charges for covered Services you receive related to conception, pregnancy, or delivery in connection with a surrogacy arrangement ("Surrogacy Health

Services"). Your obligation to pay us for Surrogacy Health Services is limited to the compensation you are entitled to receive under the surrogacy arrangement. A surrogacy arrangement is one in which you agree to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or your chosen 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. 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 the names and addresses of the other parties to the arrangement, and a copy of any contracts or other documents explaining the arrangement, to the following address:

Northern and Southern California Members:

Kaiser Permanente
Special Recovery Unit
Parsons East, Second Floor
P.O. Box 7017
Pasadena, CA 91109-9977

Attention: Third-Party Liability Supervisor

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 must not take any action prejudicial to our rights.

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 a "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:
  1. From any source providing a Financial Benefit or from whom a Financial Benefit is due; or

2. 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.

Requests for Payment or Services

Requests for payment

Non-Plan Emergency Care, Out-of-Area Urgent Care, or Post-stabilization Care. If you receive Emergency Care, Out-of-Area Urgent Care, or Post-stabilization Care from a non-Plan Provider as described in the "Emergency, Urgent, and Routine Care" section, you must file a claim in order for us to consider your request to pay for the Services. This is what you need to do:

- As soon as possible, obtain our claim form by calling our Member Service Call Center toll free at **1-800-464-4000 or 1-800-390-3510, (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**
- If you have paid for the Services, you must send us our completed claim form for reimbursement. Please attach any bills from the non-Plan Provider and receipts.
- To request that a non-Plan Provider be paid for Services, you must send us our completed claim form and include any bills from the non-Plan Provider. If the non-Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If you later receive any bills from the non-Plan Provider, please call our Member Service Call Center toll free at **1-800-464-4000 or 1-800-390-3510, (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week,** to confirm that we have received everything we need.
- You must complete and return to us any information that we request to process your claim, such as claims forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled.
- Any additional information we request should also be mailed to the following addresses:

Northern California Members:

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

Southern California Members:

Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 7102
Pasadena, CA 91109-9880

We will send you our written decision within 30 days after we receive the claim from you or the non-Plan Provider unless we notify you, within that initial 30 days, that we need additional information from you or the non-Plan Provider. We must receive the additional information within 45 days of our request in order for the information to be considered in our decision. We will send you our written decision within 15 days of receiving the additional information. However, if we don't receive the additional information within 45 days of our request, we will send you our written decision no later than 90 days from the date of your initial request for payment.

If we deny your claim in whole or in part, we will send you a written decision that fully explains why we denied it and how you can file a grievance.

Other Services

To request payment for Services that you believe should be covered, other than Services described above, you must submit a written request to your local Member Services Department at a Plan Facility. Please attach any bills and receipts, if you have paid any bills.

We will send you our written decision within 30 days unless we notify you, within that initial 30 days, that we need additional information from you or the non-Plan Provider. We must receive the additional information within 45 days of our request in order for the information to be considered in our decision. We will send you our written decision within 15 days of receiving the additional information. However, if we don't receive the additional information within 45 days of our request, we will send you our written decision no later than 90 days from the date of your initial request for payment.

If we deny your request in whole or in part, our written decision will fully explain why we denied it and how you can file a grievance.

Requests for Services

Standard decision. Plan Providers make the decisions about which Services are right for you. If you have received a written denial of Services from Medical Group or a "Notice of Non-Coverage" and you want to request that we cover the Services, you can file a grievance as described in the "Dispute Resolution" section.

If you haven't received a written denial of Services, you may make a request for Services orally or in writing to your local Member Services Department at a Plan Facility. You will receive a written decision within 15 days unless you are notified that additional information is needed. The additional information must be received within 45 days of the request for information in order for it to be considered in the decision. You will receive a written decision within 15 days of our receipt of the additional information. If you don't supply the additional information within 45 days of the request, you will receive a written decision no later than 75 days after the date you made your request to Member Services.

If your request is denied in whole or in part, the written decision will fully explain why your request was denied and how you can file a grievance.

If you believe we should cover a Medically Necessary Service that is not a covered benefit under this *DF/EOC,* you may file a grievance as described in the "Dispute Resolution" section.

Expedited decision. You or your physician may make an oral or written request that we expedite our decision about your grievance if it involves imminent and serious threat to your health, such as severe pain or potential loss of life, limb, or major bodily function. We will inform you of our decision within 72 hours (orally or in writing).

If the request is for a continuation of an expiring course of treatment, and you make the request at least 24 hours before the treatment expires, we will inform you of our decision within 24 hours.

You or your physician must request an expedited decision in one of the following ways and you must specifically state that you want an

"expedited decision:"

- Call toll free **1-888-987-7247.**
- Send your written request to:

  Kaiser Foundation Health Plan, Inc.
  Advocacy Program
  P.O. Box 12983
  Oakland, CA 94604-2983
  Attention: Expedited Review

- Fax your written request to **1-888-987-2252.**
- Deliver your request in person to your local Member Services Department at a Plan Facility.

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 DMHC directly at any time without first filing a grievance with us.

Dispute Resolution

Special note to Medicare Members: Please refer to "Dispute Resolution" in "Section Two, Senior Advantage Plan" of this booklet for details about the dispute resolution process for Medicare Members.

Grievances

We are committed to providing you with quality care, and with a timely response to your concerns if an issue arises. Our Member Service representatives are available to discuss your concerns at most Plan Facilities or you can call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY) 7 a.m. to 7 p.m., seven days a week.**

You can file a grievance for any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about the Services you received. You may submit your grievance as follows:

- To a Member Service representative at your local Member Services Department at a Plan Facility (please refer to *Your Guidebook* for locations).
- Through our Web site at *www.members.kp.org*
- The following locations for claims described under "Non-Plan Emergency Care, Out-of-Area Urgent Care, or Post-stabilization Care" in the "Requests for payment" section:

Northern California Members:

Kaiser Permanente
Special Services Unit
P.O. Box 23280
Oakland, CA 94623

Southern California Members:

Kaiser Permanente
Special Services Unit
P.O. Box 7136
Pasadena, CA 91109

We will send you a confirming letter within five days of our receipt of your grievance.

We will send you our written decision within 30 days. If we deny your grievance in whole or in part, our written decision will fully explain why we denied it and additional dispute resolution options.

■ Expedited grievance

You or your physician may make an oral or written request that we expedite our decision about your grievance if it involves imminent and serious threat to your health, such as severe pain or potential loss of life, limb, or major bodily function. We will inform you of our decision within 72 hours (orally or in writing).

We will also expedite our decision if the request is for a continuation of an expiring course of treatment.

You or your physician must request an expedited decision in one of the following ways and you must specifically state that you want an "expedited decision:"

- Call toll free **1-888-987-7247.**
- Send your written request to:

Kaiser Foundation Health Plan, Inc.
Advocacy Program
P.O. Box 12983
Oakland, CA 94604-2983
Attention: Expedited Review

- Fax your written request to **1-888-987-2252.**
- Deliver your request in person to your local Member Services Department at a Plan Facility.

If we deny your request for an expedited decision, we will notify you and we will respond to your grievance within 30 days. If we deny your grievance in whole or in part, our written decision will fully explain why we denied it and provide additional dispute resolution options.

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 DMHC directly at any time without first filing a grievance with us.

Providing supporting documents for your request

It is helpful for you to include any information that clarifies or supports your position. You may want to include with your grievance supporting information, such as medical records or physician opinions in support of your request. When appropriate, we will request medical records from Plan Providers on your behalf. If 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 medical records. We will ask you to send or fax us a written authorization so that we can request your records. If we do not receive the information we request in a timely fashion, we will make a decision based on the information we have.

Who may file

The following persons may file a grievance:

- You may file for yourself.
- You may appoint someone as your authorized representative by completing our authorization form. Authorization forms are available from your local Member Services Department at a Plan Facility or by calling our Member Service Call Center. (Your completed authorization form must accompany the grievance.)
- You may file for your Dependent children, except that they must appoint you as their authorized representative if they have the legal right to control release of information that is relevant to the grievance.
- You may file for your ward if you are a court-appointed guardian.
- You may file for your conservatee if you are a court-appointed conservator.
- You may file for your principal if you are an agent under a health care proxy, to the extent provided under state law.
- Your physician may request an expedited grievance as described under “Expedited grievance” above.

DMHC complaints

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service Plans. If

you have a grievance against your Health Plan, you should first telephone your Health Plan at toll free **1-800-464-4000** 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 Web site **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 (DMHC). The DMHC 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: (1) you have a recommendation from a provider requesting Medically Necessary Services, (2) you have received Emergency Care or urgent care from a provider who determined the Services to be Medically Necessary, or (3) you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition;
- Your request for payment or a Service has been denied, modified, or delayed based in whole or in part on a decision that the Service is not Medically Necessary; and
- 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 expedited grievances). The DMHC 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 DMHC determines that your case is eligible for IMR, it will ask us to send your case to the DMHC's Independent Medical Review organization. The DMHC 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 five days of making 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:

1. 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.
2. 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.
3. 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 *DF/EOC*. 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:

1. The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *DF/EOC* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. (Health Plan), including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, Services, irrespective of the legal theories upon which the claim is asserted;
2. 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; and
3. The claim is *not* within the jurisdiction of the Small Claims Court.

As referred to in this "Binding arbitration" section,

1. "Member Parties" include:
   a. A Member; or
   b. A Member's heir or personal representative; or
   c. Any person claiming that a duty to him or her arises from a Member's relationship to one or more Kaiser Permanente Parties.
2. "Kaiser Permanente Parties" include:
   a. Kaiser Foundation Health Plan, Inc. (Health Plan);
   b. Kaiser Foundation Hospitals (KFH);
   c. The Permanente Medical Group, Inc. (TPMG);
   d. Southern California Permanente Medical Group (SCPMG);
   e. The Permanente Federation, LLC;
   f. The Permanente Company, LLC;
   g. Any KFH, TPMG, or SCPMG physician;
   h. Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties; or
   i. Any employee or agent of any of the foregoing.
3. "Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts a claim as described above.
4. "Respondent" refers to a Member Party or a Kaiser Permanente Party against whom a claim is asserted.

Arbitration Oversight Board and Independent Administrator. In 1997, Health Plan assembled a Blue Ribbon Panel to evaluate the arbitration system and recommend improvements. The Panel's recommendations included the establishment of an Independent Administrator to oversee the arbitration process and an Advisory Committee with broad representation to assist in the independent administration. The Independent Administrator and the Advisory Committee established Rules of Procedure applicable to Health Plan's arbitration system. In 2002, the Advisory Committee was replaced by an Arbitration Oversight Board.

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 all claims against Respondents that are based on the same incident, transaction, or related circumstances in the Demand for Arbitration.

Serving Demand for Arbitration. Health Plan, KFH, TPMG, SCPMG, 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:

Northern California Members:

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

Southern California Members:

Kaiser Foundation Health Plan, Inc.
Legal Department
393 E. Walnut Street
Pasadena, CA 91188

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 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 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 the Kaiser Permanente Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

Number of Arbitrators. The number of Arbitrators may affect the Claimant's responsibility for paying the Neutral Arbitrator's fees and expenses.

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 a 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 Arbitrator fees and expenses. Health Plan will pay the fees and expenses of the Neutral Arbitrator under certain conditions as set forth in the *Rules for Kaiser Permanente Member*

Arbitrations Overseen by the Office of the Independent Administrator (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.

Rules of Procedure. Arbitrations shall be conducted according to Rules of Procedure developed by the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from the Member Service Call Center by calling toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

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 Respondents served by the applicable statute of limitations; or
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 (i) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (ii) 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 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 noneconomic 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 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 section.

Termination of Membership

The University 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, 2004, your last minute of coverage was at 11:59 p.m. on December 31, 2003). 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 *DF/EOC* after your Membership terminates, except as provided under "Payments after termination" in this "Termination of Membership" section.

This section describes how your Membership may end and explains how you may be able to maintain Health Plan coverage without a break, if your Membership under this *DF/EOC* ends.

Termination of *Group 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 due to loss of eligibility

If you met the eligibility requirements listed under the "Who is eligible" section when you initially enrolled, but at some future date you no longer meet these eligibility requirements, your Membership will terminate. Please check with your Group Benefits Administrator to confirm your termination date. In addition, your Dependents' Membership ends at the same time the Subscriber's Membership ends.

The University of California establishes its own health plan criteria for when group coverage for employees and Annuitants ceases, based on the University of California Group Insurance Regulations. Portions of these regulations are summarized below:

1. **Leave of absence.** Your coverage is not automatically continued during a leave without pay. If you wish to continue your coverage while on leave, you must make payment for the full cost of the plan (including the employer contribution) directly to the local Accounting or Benefits Office. If you do not continue coverage during your leave, you must re-enroll upon return to active status. Contact your benefits representative for information about continuing your coverage in the event of a leave of absence.
2. **Subscriber and Dependents.** Group coverage ceases for a Subscriber and all enrolled Dependents when the Subscriber ceases to be eligible for group coverage. Coverage for an employee ends on the last day of the last pay period for which the employee has an eligible appointment and premiums are paid.
3. **Dependents only.** When your family members no longer meet the eligibility requirements for coverage as Dependents, their right to receive benefits ends on the last day of the

month in which the family member is no longer eligible.

Spouse: In the event of divorce, legal separation, or annulment, a Spouse loses eligibility as a Dependent at the end of the month in which the action is final.

Adult Dependent relative or same-sex domestic partner: When you no longer meet the University of California's eligibility requirements.

Child: Your child loses eligibility as a Dependent:

- At the end of the month in which the child marries, regardless of age; or
- At the end of the month in which the child reaches the group age limit(s) for continuing group coverage or ceases to meet any other eligibility requirements for dependency status specified in your *Group Agreement.*

Exception: We will continue coverage for a Dependent who is incapable of self-support due to a physical or mental handicap as specified in the "Who is eligible" section of this booklet. You must furnish us with proof of his or her incapacity and dependency within 31 days after we request it.

If your Membership under this *DF/EOC* ends, you may be eligible to maintain Health Plan Membership without a break in coverage under this *DF/EOC* (group coverage) or you may be eligible to convert to a nongroup Plan (Individual Plan). Please see the "Continuation of Membership" section for details.

You must notify the University immediately of any changes that may affect eligibility of any enrolled family member.

Termination for cause

If you commit one of the following acts, we may terminate your Membership immediately by sending written notice to the Subscriber; termination will be effective on the date we send the notice:

1. Your behavior threatens the safety of Plan personnel, or of any person or property at a Plan Facility.
2. You commit theft from Health Plan, from a Plan Provider, or at a Plan Facility.
3. You knowingly commit fraud in connection with Membership, Health Plan, or a Plan Provider. Some examples of fraud include:
   - Misrepresenting eligibility information about you or a Dependent;
   - Presenting an invalid prescription or physician order;
   - Misusing a Health Plan ID card (or letting someone else use it);
   - Giving us incorrect or incomplete material information; or
   - 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, except that Subscribers who are terminated for fraud may be allowed to enroll themselves and their Dependents under this *DF/EOC* 18 months after the termination date. We may report fraud and other illegal acts to the authorities for prosecution.

Termination for nonpayment

■ Nonpayment of Dues

If your Group fails to pay us the appropriate Dues for your Family Unit, we may terminate the Memberships of everyone in your Family Unit.

Partial payment of Dues for a Family Unit. If your Group makes a partial Dues payment specifically for your Family Unit and does not pay us the entire Dues required for your Family Unit, we will terminate the Memberships of everyone in the Family Unit at 11:59 p.m. on the last day of the month in which our determination is made. We will send written notice of the termination to the Subscriber at least 15 days before the termination date. Also, if we terminate your Membership, we will reinstate your Membership without a lapse in coverage, if we receive full payment from your Group on or before your Group's next scheduled payment due date.

For Members who are eligible for Medicare as primary coverage, Dues are based on the assumption that Health Plan or its designee will receive Medicare payments for Medicare-covered Services provided to Members eligible for benefits under Medicare Part A or Part B (or both). If you are or become eligible for Medicare as primary coverage, you must comply with the following requirements:

- Enroll in all parts of Medicare for which you are eligible and continue that enrollment while a Member;
- Be enrolled through your group in Kaiser Permanente Senior Advantage; and
- Complete and submit all documents necessary for Health Plan, or any provider from whom you receive Services covered by Health Plan, to obtain Medicare payments for Medicare-covered Services provided to you.

If you do not comply with all of these requirements for any reason, even if you are unable to enroll in Kaiser Permanente Senior Advantage because you do not meet the Plan's eligibility requirements, the Plan is not available through your Group, or Senior Advantage is closed to enrollment, we will increase your Group's Dues to compensate for the lack of Medicare payment and transfer your Membership to our non-Medicare Plan if you are not already so enrolled. However, if your Group does not pay us the entire Dues required for your Family Unit, we will terminate the Memberships of everyone in the Family Unit in accord with this section.

Note: Medicare is the primary coverage except when federal law requires that the group's health care plan be primary and Medicare coverage be secondary.

■ Nonpayment of any other Charges

We may terminate your Membership if you fail to pay any amount you owe Health Plan or a Plan Provider. We will send written notice of the termination to the Subscriber at least 15 days before the termination date. If we receive full payment before the termination date, we will not terminate your Membership. Also, if we terminate your Membership for nonpayment of other Charges, we will reinstate your Membership without a lapse in coverage, if we receive full

payment on or before the next scheduled payment due date.

Persons whose Memberships are terminated for nonpayment of other Charges may not enroll in Health Plan unless all amounts owed have been paid, and then, only if we approve the enrollment.

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 by law. If we discontinue offering a particular product in a market, we will terminate just the particular product upon 90 days prior written notice to you. If we discontinue offering all products to groups in a small or large group market, as applicable, we may terminate the *Group Agreement* upon 180 days prior written notice to you.

Certificates of Creditable Coverage

The Health Insurance Portability and Accountability Act requires employers or health plans to issue "Certificates of Creditable Coverage" to terminated group Members. The certificate documents health care Membership and is used to prove prior creditable coverage when a terminated Member seeks new coverage. When your Membership terminates, we will mail the certificate to the Subscriber. If you have any questions, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week).**

Payments after termination

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

- Refund any amounts we owe the University for Dues paid for the period after the termination date; and
- Pay you any amounts we have determined that we owe you for claims during your Membership in accord with "Non-Plan Emergency Care, Out-of-Area Urgent Care, or Post-stabilization Care" in the "Requests for Payment or Services" section. Any amounts you owe Health Plan, Kaiser Foundation Hospitals, or Medical Group will be deducted 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 "DMHC complaints" in the "Dispute Resolution" section).

Continuation of Membership

If your Membership under this *DF/EOC* ends, you may be eligible to maintain Health Plan Membership without a break in coverage under this *DF/EOC* (group coverage) or you may be eligible to convert to an individual (nongroup) Plan.

Continuation of Group coverage under federal or state law (COBRA)

You may be able to continue your coverage under this *DF/EOC* for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. COBRA applies to employees (and their covered family Dependents) of most employers with 20 or more employees. Members are not ineligible for COBRA continuation coverage solely because they live in the service area of a Region outside California.

You must submit a COBRA Election Form to your Group within the COBRA election period. Please ask your Group's Benefits Administrator for the details about COBRA continuation coverage, such as how to elect coverage and how much you must pay your Group.

As described in "Conversion of Group Membership to an Individual Plan" in this section, you may be able to convert to an individual (nongroup, including HIPAA) Plan if you do not 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 in "Cal-COBRA after exhausting COBRA" and "State Continuation Coverage after COBRA or Cal-COBRA coverage."

■ Cal-COBRA after exhausting COBRA

In certain cases, if you would otherwise lose COBRA coverage, you may be able to continue uninterrupted Group coverage under this *DF/EOC* for a limited time upon arrangement with us in compliance with Cal-COBRA, and upon payment of applicable monthly Dues to Health Plan, 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 are not entitled to Medicare; and
- You pay us the monthly Dues by the billing due date described under "How to request enrollment and paying Dues."

As described in "Conversion of Group Membership to an Individual Plan," 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. Also, if you enroll in Cal-COBRA and exhaust the time limit for Cal-COBRA coverage, you may be able to continue Group coverage under state law as described under "State Continuation Coverage after COBRA or Cal-COBRA coverage."

How to request enrollment and paying Dues. Within 63 days of the date of our termination letter or of your Membership termination date (whichever date is later), you must request an enrollment application by calling our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7. a.m. to 7 p.m., seven days a week.** Within 10 days of your request, we will send you our enrollment application, which will include Dues and billing information. You must return your completed application promptly.

If we approve your enrollment application, we will send you a bill within 30 days after we receive your application. You will have 45 days to pay the bill. The first Dues payment will include coverage from when you exhausted COBRA coverage through our current billing cycle. If you do not send us the Dues payment by the due date on the bill, you will not be enrolled in Cal-COBRA.

Thereafter, monthly Dues payments are due on or before the last day of the month proceeding the month of coverage. The Dues will not exceed 110 percent of the applicable Dues for covered employees, except for disabled individuals. For Dependents, the Dues will not exceed 110 percent of the applicable Dues charged to a similarly situated individual under the group benefit plan, except for disabled individuals. In the case of disabled individuals after 18 months of COBRA coverage, the percentage is 150 percent instead of 110 percent.

Termination of Cal-COBRA continuation coverage. Cal-COBRA coverage continues only upon payment of applicable monthly Dues 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 become entitled to 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 expiration of 36 months after your original COBRA effective date (under this or any other plan); or
- If we do not receive your entire Dues payment on or before the last day of the month proceeding the month of coverage, we will send written notice of the termination to the Subscriber at least 15 days before the termination date. You are responsible for paying all Dues for the period prior to the termination date. If we receive full payment before the termination date, we will not terminate your Membership. Also, if we terminate your Membership for nonpayment of Dues, we will reinstate your Membership without a lapse in coverage if we receive full payment on or before the next scheduled payment due date following the one you missed.

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: (i) the expiration of 36 months after your original COBRA effective date, or (ii) 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.

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.

To continue your Cal-COBRA coverage with us, you must request an enrollment application during your Group's open enrollment period, or within 63 days of receiving the termination notice from your Group described below. To request an application, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.** We will send you our enrollment application and you must return your completed application promptly. If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You will have 45 days to pay the bill. If you do not send us the Dues payment by the due date on the bill, you will not be enrolled in Cal-COBRA.

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

State Continuation Coverage after COBRA or Cal-COBRA coverage

If you lose eligibility for COBRA or Cal-COBRA coverage because you exhaust the time limit for coverage, you may be eligible to continue your Group coverage for a limited time under state law (State Continuation Coverage) if required by Section 1373.621 of the California Health and Safety Code.

To enroll in State Continuation Coverage, you must request enrollment by calling our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** within 30 days before your COBRA or Cal-COBRA coverage is exhausted, and meet one of the following requirements:

- You are a Subscriber, and on the date your employment with your Group ended you were at least 60 years old and had been employed by your Group for at least five years; or you are the Spouse of such a Subscriber;
- You are the Spouse of a Subscriber who dies, legally separates, or becomes entitled to Medicare; or
- You are a former Spouse of a Subscriber.

Dues

You must send us the first Dues payment within 45 days of the date you send us your completed application requesting this coverage. The first payment will include coverage from when you exhausted COBRA or Cal-COBRA coverage through our current billing cycle. If you do not send us the Dues payment within 45 days, you will not be enrolled in State Continuation Coverage.

The Dues under this plan are different from those under COBRA and Cal-COBRA. The Dues will not exceed 213 percent of the applicable Dues for a similarly situated individual under the Group benefit plan.

Termination of State Continuation Coverage

Coverage terminates on the earliest of:

- The date your Group's *Agreement* with us terminates;
- The date you obtain coverage under any other group health plan not maintained by your Group, regardless of whether that coverage is less valuable;
- The date you become entitled to Medicare;
- Your 65th birthday;
- Five years from the date your COBRA or Cal-COBRA coverage was scheduled to end, if you are a Subscriber's Spouse or former Spouse; or
- If we do not receive your entire Dues payment on or before the last day of the month preceding the month of coverage, we will send written notice of the termination to the Subscriber at least 15 days before the termination date. You are responsible for paying all Dues for the period prior to the termination date. If we receive full payment before the termination date, we will not terminate your Membership. Also, if we terminate your Membership for nonpayment of Dues, we will reinstate your Membership without a lapse in coverage if we receive full payment on or before the next scheduled payment due date following the one you missed.

If you do not elect State Continuation Coverage, you may be able to convert to an Individual (nongroup) Plan as described in "Conversion of Group Membership to an Individual Plan." For more information, call our Member Service Call Center.

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 *DF/EOC* for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. Members are not ineligible for USERRA

Continuation Coverage solely because they live in the service area of a Region outside California. You must submit an USERRA Election Form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage and how much you must pay your Group.

Conversion of Group Membership to an Individual Plan

Your Group is required to inform the Subscriber of the date your coverage ends (please check with your Group's Benefits Administrator to confirm your Membership termination date). 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 Individual (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." The Dues and coverage under our Individual (Conversion) Plan will differ from those under this *DF/EOC*. You may be eligible to enroll in our Individual (Conversion) Plan if you no longer meet the eligibility requirements described in the "Who is eligible" section. Also, if you enroll in Group Continuation Coverage through COBRA, Cal-COBRA, USERRA, or State Continuation Coverage after COBRA or Cal-COBRA coverage, you may be eligible to enroll in our Individual (Conversion) Plan when your Group continuation coverage ends.

To be eligible for our Individual (Conversion) Plan, there must be no lapse in your coverage and you must request an enrollment application by calling our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** within 63 days of the date of our termination letter, or of your Membership termination date, whichever date is later. We will send you our enrollment application and you must return your completed application promptly. If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You will have 45 days to pay 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. If you do not send us the Dues payment by the due date on the bill, you will not 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, USERRA, or State Continuation Coverage after COBRA or Cal-COBRA coverage);
- Your Membership ends because our *Agreement* with your Group terminates and it is replaced by another plan within 15 days of the termination date;

- We terminated your Membership under "Termination for cause" or "Nonpayment of any other Charges"; or
- 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 are not ineligible to be covered Dependents solely because they live in a non-California Region (please refer to the "Who is eligible" section for more information).

HIPAA and other individual Plans

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health coverage for workers and their families when they change or lose their jobs. If you lose group health coverage and meet certain criteria, you are entitled to purchase individual (nongroup) health coverage from any health plan that sells individual health coverage.

Every health plan that sells individual health 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 Dues or fraud.
- You are not eligible for coverage under a group health plan, Medicare, or Medicaid (Medi-Cal).
- You have no other health coverage.
- You have elected and exhausted any continuation coverage you were offered under COBRA or Cal-COBRA.

For more information (including Dues and complete eligibility requirements), please refer to the KP HIP (the Kaiser Permanente HIPAA Individual Plan) *Evidence of Coverage (EOC)*. To request a copy of the KP HIP *EOC* or for information about other individual plans, such as Kaiser Permanente Personal Advantage, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

Coverage for disabling condition if your Group's *Agreement* terminates

If you became totally disabled after December 31, 1977, 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, coverage for your disabling condition will continue until any one of the following events occur:

- 12 months have elapsed;
- You are no longer disabled; or

- 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 *DF/EOC,* including Copayments and Coinsurance.

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 Call Center toll free at**1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** within 30 days of the date your Group's *Agreement* with us terminates.

SECTION TWO

Kaiser Permanente Senior Advantage Plan

Kaiser Permanente

Disclosure Form and

Evidence of Coverage

for the

University of California

Effective January 1, 2004

Member Service Call Center

1-800-443-0815
7 a.m. to 7 p.m., seven days a week

Hearing and speech impaired
1-800-777-1370 (TTY)

www.members.kp.org

SECTION TWO

Kaiser Permanente Senior Advantage Plan

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Senior Advantage Plan Summary of Changes Effective January 1, 2004

■ Benefit and Copayment changes

Please refer to the "Benefits" section of this *Disclosure Form / Evidence of Coverage (DF/EOC)* for benefit descriptions and the "Copayments and Coinsurance" section for the amount Members must pay for covered benefits. Benefits are also subject to the "Exclusions, Limitations, and Reductions" section.

Dental Services for radiation treatment and dental anesthesia. We have added "Dental Services for radiation treatment and dental anesthesia" to the "Benefits" section to clarify our coverage of dental-related Services.

Drug refills. We have added a provision saying that Members may be able to obtain refills through our Web site at *www.members.kp.org.* Also, most Plan Pharmacies offer refills by mail, but a few Plan Pharmacies don't dispense covered refills (Members should refer to their *Guidebook to Kaiser Permanente Services* or ask their Plan Pharmacy for details).

Durable medical equipment (DME). We have added information about our DME formulary and how we maintain it.

Home health care. We have revised our home health care description for clarity. Also, we have added these two 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; or
- Care in the home if the home is not a safe and effective treatment setting.

We deleted the exclusion under home health care relating to custodial care because it was unnecessary. Custodial care is a general exclusion that applies to all benefits (except covered hospice care) as described in the "Exclusions" section of this *DF/EOC.*

Mental health group therapy visits. Mental health group visits will be provided at one-half the mental health individual visit Copayment, rounded down to the nearest dollar.

Ostomy and urological supplies. We have created a soft goods formulary for ostomy and urological supplies. Previously these items were included in the durable medical equipment formulary. We have also added information about our soft goods formulary and how we maintain it.

Out-of-Pocket Maximum. We have expanded the list of Services that apply to the annual Out-of-Pocket maximum (please refer to the "Benefit Summary, and Copayment and Coinsurance" section for the Services that apply to the maximum).

Transplant Services. We have removed the exclusion for nonhuman and artifi-

cial organs because we cover Medically Necessary transplants as described in the "Transplant Services" section.

Eligibility, enrollment, and changes to our Service Area

The following changes have been made to provisions concerning eligibility, enrollment, and our Service Area:

- The "Service Area" section in "Section Three, General Information for All Members" includes ZIP code revisions and we have clarified that ZIP codes can change at any time when the U.S. Postal Service makes a change.
- We have clarified in the "Service Area" section in "Section Three, General Information for All Members" in this *DF/EOC* that we may expand the Service Area at any time by giving notice to your Group.

Northern California Members

- For Kaiser Permanente Senior Advantage Members, any Service Area reductions are effective on January 1 of each year upon notice to your Group and in accord with requirements of the Centers for Medicare & Medicaid Services (CMS), (see the "Definitions" section in this *DF/EOC*).

Southern California Members

- For Kaiser Permanente Senior Advantage Members, any Service Area reductions are effective on January 1 of each year upon notice to Group and in accord with CMS requirements. Please be advised that the Service Area for Senior Advantage no longer includes western Ventura County effective January 1, 2004. CMS requires that Senior Advantage Members reside inside the Service Area to be eligible for Senior Advantage Membership. Therefore, Members who live in western Ventura County must be disenrolled from Senior Advantage effective January 1, 2004 (see the "Definitions".
- The following persons are barred from enrollment (changes are underlined):
  - persons who have had their entitlement to receive Services through Health Plan either rescinded or terminated for cause cannot enroll; or
  - persons who had entitlement to receive Services through Health Plan terminated for failure to pay individual (nongroup) Plan Dues or failure to pay any amounts owed to Health Plan or a Plan Provider cannot enroll, unless we agree to allow you to enroll after you pay all amounts owed by you and your Dependents.

Exclusions, Limitations, and Reductions

The following changes have been made to the "Exclusions, Limitations, and Reductions" section:

- We clarified that when a Service is not covered, all Services related to the noncovered Service are excluded, except that this exclusion does not apply to Services we would otherwise cover to treat complications of the noncovered Service.
- We have deleted the exclusion for Services not available within our Service Area.

- We have revised the "Limitations" section to state that we will do our best to provide or arrange for our Members' health care needs in the event of unusual circumstances that delay or render impractical the provision of Services under this *DF/EOC,* such as 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 disputes.

How to Obtain Services and Plan Facilities

We have clarified the "How to Obtain Services" section to provide additional information about Medical Group authorization procedures. We have created a new section called "Plan Facilities," which lists all Plan Hospitals and most Plan Medical Offices. Also, the "Definitions" section has also been revised to address the new section in the definitions of Plan Hospital, Plan Medical Office, Plan Provider, Plan Facilities, and Plan Pharmacy.

Post-stabilization Care

We have clarified the description of Post-stabilization Care to include more information about Medically Necessary transportation. Please refer to the "Emergency, Urgent, and Routine Care" section in this *DF/EOC* for coverage information.

Requests for payment or Services and dispute resolution

We have added more information about expedited grievances.

Termination for cause

We have revised our termination-for-cause provision as follows:

- We have clarified that a Membership may be terminated for cause if the Member commits theft from Health Plan, from a Plan Provider, or at a Plan Facility.
- We have clarified the termination effective date.
- We may report fraud and other illegal acts to the authorities for prosecution.

Termination and continuation of coverage

We have created a new section called "Continuation of Membership." It discusses the options to continue coverage through your Group (COBRA) and under an individual (nongroup) Plan when COBRA coverage has been exhausted. Members must call us to apply for individual (nongroup) coverage within 63 days of the date of our termination letter, or of their Membership termination date, whichever date is later.

Also, Members will now be eligible for conversion to our individual (nongroup) Plan if your Group's *Agreement* with us terminates, unless it is replaced by another Plan within 15 days of the termination date.

Terminology (defined terms)

The following definitions have been added or revised for clarity (refer to the "Definitions" section for more information):

- Charges
- Coinsurance

- Copayment
- Emergency Care
- Plan Facility
- Plan Hospital
- Plan Medical Office
- Plan Pharmacy
- Plan Provider
- Post-stabilization Care
- Service Area (see discussion in "Eligibility, enrollment, and changes to our Service Area above)
- Skilled Nursing Facility

Copayments and Coinsurance

This section lists Kaiser Permanente Senior Advantage Plan Copayments and Coinsurance only. It does not describe benefits. To learn what is covered for each benefit **(including any visit and day limits),** please refer to the identical heading in the "Benefits" section (also refer to the "Exclusions, Limitations, and Reductions" section, which applies to all benefits).

Copayments or Coinsurance are due when you receive Services, but for items ordered in advance, you pay the Copayment or Coinsurance in effect on the order date (though we will not cover the item unless you still have coverage for it on the date you receive it). In some cases, we may agree to bill you for your Copayment. If we agree to bill you, we will increase the amount by $13.50 and mail you a bill for the entire amount.

Copayments

Annual Out-of-Pocket Maximum:

One Member	$1,500
Subscriber and all of his or her Dependents	$3,000

Category	***Copayment***
Hospital inpatient care	
Hospital inpatient care, including physician Services	$250 per admission
Outpatient care	
Primary and specialty care visits includes routine and urgent care appointments)	$10 per visit
Gynecological visits	$10 per visit
Pediatric visits	$10 per visit
Preventive health screenings (including colonoscopy and sigmoidoscopy)	$10 per visit
Scheduled prenatal care and the first postpartum visit	No charge
Well-child preventive care visits (age 23 months or younger)	No charge
Outpatient surgery	$10 per procedure
Allergy testing visits	$10 per visit
Allergy injection visits	$3 per visit
Blood, blood products, and their administration	No charge
Immunization/Inoculation	No charge
Manual manipulation of the spine to cover subluxation	$10 per visit
Ambulance Services	
Emergency ambulance Services	No charge
Nonemergency ambulance Services as defined in the "Benefits" section	No charge
Chemical dependency Services	
Inpatient detoxification	$250 per admission
Outpatient individual therapy	$10 per visit
Outpatient group therapy	$5 per visit
Transitional residency recovery Services	$100 per admission

Category	*Copayment*
Dental Services for radiation treatment, dental anesthesia	
Dental Services for radiation treatment	$10
Dental anesthesia	The amount you would pay for hospital inpatient care or outpatient surgery depending on the setting
Dialysis care	
Inpatient care	$250 per admission
Physician office visits	$10 per visit
Dialysis treatment visits	No charge
Drugs, supplies, and supplements	
Items described in the "Benefits" section under the heading "Administered drugs and self-administered IV drugs"	No charge
Diabetes urine-testing supplies	No charge (up to a 100-day supply)
Certain insulin-administration devices	$10 generic (up to a 100-day supply)
Items described in the "Benefits" section under the heading "Outpatient drugs, supplies, and supplements"	$10 generic/$20 brand name (up to a 100-day supply, or 3 cycles for oral contraceptives)
Drugs covered by Medicare	No charge
Copayments and Coinsurance for the following are as indicated:	
Amino acid-modified products used to treat congenital errors of amino acid metabolism and elemental dietary enteral formula when used as a primary therapy for regional enteritis.	No charge (up to a 30-day supply)
Emergency contraceptive pills	No charge
Drugs related to the treatment of sexual dysfunction disorders:	
Episodic drugs are provided up to a supply maximum of 27 doses in any 100-day period	50% Coinsurance (up to a 100-day supply)
Maintenance (nonepisodic) drugs that require doses at regulated intervals	50% Coinsurance (up to a 100-day supply)

Note: *You will pay the Copayment or Charges for drugs, supplies, and supplements, whichever is less.*

Limitation: *The day supply dispensed at the Copayment and Coinsurance may be reduced (a) to a 30-day supply maximum in any 30-day period for specific drugs (please call our Member Service Call Center for the current list of these drugs), or (b) if the pharmacy limits the amount dispensed because the drug is in limited supply in the market. Also, the Copayment or Coinsurance applies to each prescription as prescribed by a Plan Physician not to exceed a 100-day supply. Members must pay Charges for any quantities dispensed that exceed the applicable supply maximum.*

Category	*Copayment*

Durable medical equipment (DME)

Durable medical equipment used during a covered stay in a Plan Hospital or Skilled Nursing Facility	No charge
Durable medical equipment for use in the home and/or replacement	No charge

Emergency Department visits

Emergency Department visits	$50 per visit (waived if admitted to the hospital within 24 hours for the same condition.)

Family planning Services

Inpatient Services	$250 per admission
Outpatient visits	$10 per visit

Health education

Individual visits	$10 per visit
All other covered Services	No charge

Hearing Services

Hearing tests	$10 per visit
Hearing aid(s) every 36 months, as described in the “Benefits” section	Up to a $2,500 allowance per aid, per ear

Home health care

Part-time or intermittent home health care	No charge

Hospice care

Hospice care for Members not entitled to Medicare Part A	No charge

Imaging, laboratory, and special procedures

Imaging, laboratory, special procedures, annual mammograms, and ultraviolet light treatment visits	No charge

Category	*Copayment*
Infertility Services	
Office visits	$10
Outpatient surgery	$10
Imaging, laboratory, and special procedures	No charge
Hospital inpatient care	$250
Prescribed drugs obtained at Plan Pharmacies	$10 generic/$20 brand name (up to a 100-day supply)
Mental health Services	
Inpatient psychiatric care and hospital alternative Services	$250 per admission
Hospital alternative Services	No charge
Outpatient visits	$10 per visit
Group therapy visits	$5
Ostomy and urological supplies	
Ostomy and urological supplies	No charge
Physical, occupational, and speech therapy, and multidisciplinary rehabilitation Services	
Physical, occupational, and speech therapy	
Inpatient Services	No charge
Outpatient visits	$10 per visit
Multidisciplinary rehabilitation	
Inpatient	$250
Outpatient	$10 per day
Prosthetic and orthotic devices	
Covered devices	No charge
Reconstructive surgery	
Inpatient Services	$250 per admission
Outpatient visits	$10 per visit
Outpatient surgery	$10 per procedure
Skilled Nursing Facility care	
Care in a Skilled Nursing Facility	No charge
Transplant Services	
Inpatient services	$250 per admission
Outpatient visits	$10 per visit
Urgent care	
In-area	$10 per visit at a Plan Facility; (not covered at a non-Plan Facility)
Out-of-area	$50 per visit (waived if admitted to the hospital within 24 hours for the same condition)

Category	*Copayment*
Vision Services	
Eye exams and glaucoma screening	$10 per visit
Optical Services:	
Eyeglasses and contact lenses (including fitting and dispensing) every 24 months	$150
Special contact lenses	No charge
Eyeglasses and contact lenses following cataract surgery	$150 allowance*

* Your price will be reduced by the allowance indicated. If the price of the item(s) you select exceeds the allowance, you will pay the difference.

Introduction

This *Disclosure Form and Evidence of Coverage (DF/EOC)* describes the Senior Advantage health care coverage, including additional coverage provided in the *Group Agreement* between us and the University of California (your Group). For benefits provided under any other Health Plan program, refer to that Plan's *Evidence of Coverage*. In this *DF/EOC,* Kaiser Foundation Health Plan, Inc., is sometimes called "Health Plan," "we," or "us." You, as an enrolled person, are sometimes called the "Member" or "you." Kaiser Permanente Senior Advantage Plan is sometimes called "Senior Advantage." Some capitalized terms have special meaning in this *DF/EOC.* Please see the "Definitions" section of "Section Three, General Information for All Members" for terms you should know.

This *DF/EOC* describes the benefits offered by Health Plan's Northern and Southern California Regions through the Kaiser Permanente Senior Advantage program. Eligible persons enroll in one of our California Service Areas and are provided coverage applicable to the Service Area that they are enrolled in. For benefits provided to Members not enrolled in Senior Advantage, refer to the Traditional Plan *DF/EOC* in "Section One" of this booklet.

We provide Services directly to our Members through an integrated medical care program. Our Health Plan, Hospitals, and 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, and other benefits described in the "Benefits" section.

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* DF/EOC *completely so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

When you join Kaiser Permanente, you are enrolling in one of two Regions (Northern or Southern California). When you temporarily visit the other California Region, you may receive care as a visiting Member. Please keep this booklet. If you enroll with Kaiser Permanente, it becomes your *Evidence of Coverage.*

Term of this *Disclosure Form and Evidence of Coverage*

This *DF/EOC* is in effect January 1, 2004, through December 31, 2004. Your Group's Benefits Administrator can confirm that this *DF/EOC* is still in effect and can provide you with a current one if this *DF/EOC* has expired.

About Kaiser Permanente Senior Advantage

As a Senior Advantage Member, you are selecting our medical care system to provide your health care. You must receive all covered care from Plan Providers inside our Service Area,

except as described under the following headings:

- Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care received from non-Plan Providers, in the "Emergency, Urgent, and Routine Care" section;
- "Getting a referral" in the "How to Obtain Services" section;
- "Our Visiting Member Program" in the "How to Obtain Services" section; and
- "Out-of-area dialysis care" in "Dialysis care" in the "Benefits" section.

Who is eligible

The University of California establishes its own health plan eligibility criteria for Annuitants based on the University of California Group Insurance Regulations. Portions of these regulations are summarized below.

To enroll and continue enrollment, you must reside in one of the Kaiser Permanente Senior Advantage California Service Areas and meet both the University's and Health Plan's eligibility criteria to enroll in the Plan.

You may participate in Senior Advantage if you are an eligible Annuitant and enrolled in both the hospital (Part A) and medical (Part B) parts of Medicare, unless you were enrolled in Senior Advantage on December 31, 1998, without Medicare Part A entitlement, in which case, you may continue to have Medicare Part B only. The same applies to any Dependents. Dependents who are covered by the Kaiser Permanente Traditional Plan, but not by both parts of Medicare, may continue in that Plan until they cease to be eligible. **Anyone enrolled in a non-University Medicare+Choice (a Medicare managed care HMO) contract is not eligible for this Plan.**

Eligibility requirements for Senior Advantage coverage

The University will inform you of its eligibility requirements. To enroll, you must meet the eligibility requirements established between the University and Kaiser Permanente:

- You must be entitled to benefits under both Medicare Parts A and B, except for Members enrolled in Senior Advantage on December 31, 1998, without Medicare Part A (Part B-only Members), who may continue enrollment without Medicare Part A entitlement;
- You may enroll in Senior Advantage regardless of health status, except that you may not enroll if you have end-stage renal disease (ESRD). This restriction does not apply to you if you are currently a California Health Plan Member and you develop ESRD while a Member; and
- You may not be enrolled in two Medicare-contracting HMOs at the same time. If you enroll in Senior Advantage, CMS will automatically disenroll you from any other Medicare-contracting plan.

Service Area eligibility requirements

- The Subscriber must live in one of our Service Areas, as described in "Section Three, General Information for All Members". However, if you were enrolled in Senior Advantage on December 31, 1998, and lived outside of our Service Area, you may continue your Membership unless

you move and are still outside our Service Area. The "Service Area" section describes our Service Area and how it may change.

Eligible Annuitants (including Survivor Annuitants)

You may continue University medical plan coverage when you retire (Annuitant) or start collecting disability or survivor benefits (Survivor Annuitant) from the University of California retirement plan, or any other defined benefit plan to which the University contributes, provided:

1. You meet the University's service credit requirements for Annuitant medical eligibility;
2. You were enrolled in a University medical plan immediately before retiring;
3. The effective date of your Annuitant status is within 120 calendar days of the date employment ends (or the date of the employee's/Annuitant's death in the case of a Survivor Annuitant);
4. Your medical coverage is continuous from the date employment ends; and
5. You elect to continue coverage at the time of retirement.

Enrollment of eligible dependents

If your eligible dependents meet the eligibility requirements for Senior Advantage coverage, they may enroll in Kaiser Permanente Senior Advantage as described above. If they meet the eligibility requirements for the Kaiser Permanente Traditional Plan, they should refer to "Section One, Traditional Plan" of this booklet for information about enrollment and coverage.

Eligible Dependents

Spouse: Your legal Spouse. Unless you are a Survivor Annuitant, you may not enroll your legal Spouse.

Children: Any natural or legally adopted children (or children placed with you for adoption) who are unmarried, are not emancipated minors, and are under age 23.

The following children (but not including foster children) are also eligible:

a. Any unmarried stepchildren under age 23 who reside with you, who are Dependent upon you or your Spouse for at least 50 percent of their support, and who are your or your Spouse's Dependents for income tax purposes.

b. Any unmarried grandchildren under age 23, who reside with you, who are Dependent upon you or your Spouse for at least 50 percent of their support and who are your or your Spouse's Dependents for income tax purposes.

c. Any unmarried children under age 18 for whom you are the legal guardian, who reside with you, who are Dependent upon you for at least 50 percent of their support, and who are your Dependents for income tax purposes.

Your signature on the enrollment form, or if you enroll electronically, then your electronic enrollment, attests to these conditions in (a), (b), and (c) above. You will be asked to submit a copy annually of your federal income tax return (IRS form 1040 or IRS equivalent showing the covered Dependent and your

signature) to the University to verify income tax dependency.

Any unmarried child, as defined above (except for a child for whom you are the legal guardian) who is incapable of self-sustaining employment due to a physical or mental handicap may continue to be covered past age 23 provided: The child is Dependent upon you for at least 50 percent of his/her support, is your Dependent for income tax purposes, the incapacity began before age 23, the child was enrolled in the medical plan before age 23, and coverage is continuous. Application must be made to Kaiser Permanente 31 days prior to the child's 23rd birthday and is subject to approval by the Plan. Kaiser Permanente may periodically request proof of continued disability. Your signature on the enrollment form attests to these conditions.

You will be asked to submit a copy annually of your federal income tax return (IRS form 1040 or IRS equivalent showing the covered Dependent and your signature) to the University to verify income tax dependency.

Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan. If enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If the overage handicapped child is not your natural or legally adopted child, the child must reside with you in order for the coverage to be continued past age 23.

Other eligible Dependents

You may enroll a same-sex domestic partner and their eligible children, or continue enrollment for an adult Dependent relative (enrolled prior to January 1, 2004), as set forth in the University of California Group Insurance Regulations. For information on who qualifies, and on the requirements to enroll or continue enrollment for these Dependents, contact your local Benefits Office.

Eligible persons may be covered under only one of the following categories: as an employee, as an Annuitant, as a Survivor Annuitant, or as a Dependent, but not under any combination of these. If both husband and wife are eligible, each may enroll separately or one may cover the other as a Dependent. If they enroll separately, neither may enroll the other as a Dependent. Eligible children may be enrolled under either parent's coverage, but not under both.

The University and/or Health Plan reserve the right to periodically request documentation to verify eligibility of Dependents. Such documentation could include a marriage certificate, birth certificate(s), adoption records, or other official documentation.

■ Persons barred from enrolling in Health Plan

- Persons who have had their entitlement to receive Services through Health Plan either rescinded or terminated for cause cannot enroll until you have completed a Member Orientation and have signed a statement promising future compliance.

- Persons who had entitlement to receive Services through Health Plan terminated for failure to pay individual (non-group) Plan Dues, unless we agree to allow you to enroll after you pay all amounts owed by you and your Dependents.

Note: You may be ineligible to enroll in Kaiser Permanente Senior Advantage if that Plan has reached a capacity limit that the CMS has approved. This limitation does not apply to existing Members who are eligible for Medicare (including when you turn age 65).

Moving outside our Service Area

If you permanently move outside our Service Area, as described in "Section Three, General Information for All Members," or you are temporarily absent from our Service Area for more than six months, you cannot continue your Senior Advantage Membership under this *DF/EOC*. It is in your best interest to notify us as soon as possible because until your Senior Advantage coverage is officially terminated by CMS, you will not be covered by us or Medicare for any care received outside of our Plan, except for covered care described in the "Emergency, Urgent, and Routine Care" section about "Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care" received from non-Plan Providers and "Out-of-area dialysis care" in the "Benefits" section. Send your notice to:

Northern California Members:

Kaiser Permanente
California Service Center
P.O. Box 232400
San Diego, CA 92193-2400

Southern California Members:

Kaiser Permanente
California Service Center
P.O. Box 232407
San Diego, CA 92193-2407

Moving to another service area

If you move to the Senior Advantage Plan service area of another Region, you should contact your Group's Benefits Administrator to learn about your Group health care options. You may be able to enroll in the new service area if there is an agreement between your Group and the Region but the coverage, Dues, and eligibility requirements might not be the same in the other service area.

In addition, you should consult with the University of California Customer Service Center toll free at **1-800-888-8267** to learn more about other health plan options available through your Group.

Enrollment

Annuitants and their enrolled Dependents who become eligible for Medicare hospital insurance (Part A) as primary coverage must enroll in and remain in both the hospital (Part A) and medical (Part B) portions of Medicare. This includes those who are entitled to Medicare benefits through their own or their Spouse's non-University employment. Annuitants or Dependents who are eligible for, but decline to enroll in, both parts of Medicare will be assessed a monthly offset fee by the University to cover the increased costs of remaining in the non-Medicare Plan. Annuitants or Dependents who are not eligible for Part A will not be assessed an offset fee. A notarized affidavit attesting to their ineligibility for Medicare Part A will be required. Forms

for this purpose may be obtained from the University of California's Customer Service Center toll free at **1-800-888-8267.** (Annuitants/ Dependents who are not entitled to Social Security and Medicare Part A will not be required to enroll in Part B.)

You should contact Social Security three months before your 65th birthday to inquire about your eligibility and how to enroll in the hospital (Part A) and medical (Part B) parts of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

To enroll yourself and any eligible Dependents, you must complete a University of California Medicare declaration form and a Kaiser Permanente Senior Advantage Election Form. This notifies the University that you are covered by the hospital (Part A) and medical (Part B) parts of Medicare. Medicare Declaration Forms and Kaiser Permanente Senior Advantage Election Forms are available through the University of California Customer Service Center, and completed forms should be returned to them. Upon receipt by the University of confirmation of Medicare enrollment, the Annuitant/Dependent will be changed from the Kaiser Permanente Traditional Plan for non-Medicare enrollees to the Kaiser Permanente Senior Advantage Plan for Medicare enrollees. Annuitants and Dependents are required to transfer to the Plan for Medicare enrollees.

You may also enroll yourself and any eligible Dependent(s) during your Period of Initial Eligibility (PIE), which begins on:

a. The date you have an involuntary loss of other Group medical coverage; or

b. The date you move out of a University health maintenance organization (HMO) Plan's service area on either a permanent basis, or for more than two months on a temporary basis.

If you are an Annuitant enrolled as a Spouse on a University medical Plan and become eligible for both parts of Medicare in your own right, you may enroll yourself on the earlier of:

a. The date both parts of Medicare are in effect; or

b. The effective date of retirement.

In addition, you and your eligible Dependents may enroll during a group open enrollment period established by the University.

To enroll your newly eligible Dependents, contact the University of California Customer Service Center to obtain an enrollment form and return it during the Dependent's PIE.

You may enroll Dependents during a newly eligible Dependent's PIE. The PIE starts the day your Dependent becomes eligible for benefits. For a new Spouse, eligibility begins on the date of marriage. Survivor Annuitants may not add new Spouses to their coverage.

For a newborn child, eligibility begins on the child's date of birth.

For newly adopted children, eligibility begins on the earlier of (i) the date the Annuitant or Annuitant's Spouse has the legal right to control the child's health care, or (ii) the date the child is placed in

the Annuitant's custody. If not enrolled during the PIE, beginning on that date, there is a second PIE beginning on the date the adoption becomes final.

You may also enroll your eligible Dependent during a PIE, which begins on the date he or she has an involuntary loss of other group medical coverage.

A PIE ends 31 days after it begins (or on the preceding business day for the University of California Customer Service Center if the 31st day is on a weekend or holiday).

If your Dependent fails to enroll during a PIE or open enrollment period, you may enroll your Dependent at any other time upon completion of a 90-consecutive-calendar-day waiting period. The 90-day waiting period starts on the date the enrollment form is received by the University of California Customer Service Center and ends 90 consecutive calendar days later.

An Annuitant already enrolled in employee and child(ren) and family coverage may add additional children at any time after their PIE. Retroactive coverage for such enrollment is limited to the later of:

a. A maximum of 60 days prior to the date your Dependent's enrollment form is received by the University of California Customer Service Center; or
b. The date the Dependent became eligible.

Special enrollment due to new Dependents

An Annuitant and the Annuitant's eligible Dependents may enroll within 30 days of marriage, birth, adoption, or placement for adoption by submitting to your Group an enrollment application or change of enrollment application in a form agreed upon by your Group and Health Plan. The Annuitant must enroll or be enrolled in order to enroll a family Dependent.

For specific University of California enrollment provisions, please see the "Enrollment" section above.

Effective date of Senior Advantage coverage

After we receive your completed Senior Advantage Election Form and/or electronic election, we will submit your enrollment to CMS and send you a notice indicating the effective date of your Senior Advantage coverage. Your effective date will depend on whether you are first becoming entitled to both Medicare Parts A and B, or if you are already entitled to both Medicare Parts A and B.

If you will soon become entitled to both Medicare Parts A and B and submit a timely application, your election will be effective on the first day of the month in which you are entitled to both Medicare Parts A and B. If you are already entitled to both Medicare Parts A and B, we will notify you of your effective date. Your effective date will generally be determined by the date we receive your completed Election Form and the effective date of your group coverage. There are other factors used to determine your effective date. For more information, please call our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

Once CMS confirms your enrollment, we will send you written notification. If

CMS does not confirm your enrollment in Medicare before your effective date, you still must receive your care from us (beginning on your effective date) just as if your enrollment had been confirmed. If CMS tells us that you are not entitled to both Medicare Parts A and B, we will notify you and request that you contact the Social Security Administration to clarify your Medicare status. If, after contacting the Social Security Administration, it is confirmed you are still not entitled to both Medicare Parts A and B, you will be billed as a non-Member for any Services we have provided you, unless you are an existing Member under another Kaiser Permanente Plan. Existing Members would pay the Copayments, Coinsurance, and Dues applicable to their Kaiser Permanente coverage.

Important information about Medicare supplement (Medigap) policies

If you have a Medicare supplement (Medigap) policy, you may consider canceling it after Kaiser Permanente has sent you written confirmation of your enrollment in the Kaiser Permanente Senior Advantage Plan. However, if you later disenroll from the Senior Advantage Plan, you may not be able to have your Medigap policy reinstated.

In certain cases, you can be guaranteed issuance of a Medigap policy without medical underwriting or pre-existing condition exclusions. Examples of these cases include the following:

- You are disenrolled from Senior Advantage because you moved out of our Service Area or for a reason that does not involve any fault on your part (such as Kaiser Permanente's contract with CMS terminates);
- You enrolled in Senior Advantage upon first reaching Medicare eligibility at age 65, and you disenroll from the Senior Advantage Plan within 12 months of your effective date;
- Your supplemental coverage under an employee welfare benefit Plan terminates;
- Your enrollment in a Medigap policy ceases because of the bankruptcy or insolvency of the insurer issuing the policy, or because of other involuntary termination of coverage for which there is no state law provision relating to continuation of coverage; or
- You were previously enrolled under a Medigap policy and terminated your enrollment to participate, for the first time, in the Senior Advantage Plan and you disenroll during the first 12 months.

You must apply for a Medigap policy within 63 days after your Senior Advantage Plan coverage terminates and submit evidence of the date of your loss of coverage. For additional information regarding guaranteed Medicare supplemental policies, call the Health Insurance Counseling and Advocacy Program (HICAP) toll free at **1-800-434-0222 (1-800-722-3140 TTY).**

If you choose to keep your Medicare supplement (Medigap) policy, you may not be reimbursed by the Medigap policy for Services you receive from us. Most supplemental (Medigap) policies will not pay for any portion of such Services because:

- Supplemental insurers (Medigap insurers) process their claims based on proof of an original Medicare payment, usually in the form of an

Explanation of Medicare Benefits (EOMB). However, as long as you are a Member of the Senior Advantage Plan, original Medicare will not process any claims for medical Services you receive (except hospice care for Members with Medicare Parts A and B and qualifying Clinical Trials).

- Kaiser Permanente has the financial responsibility for all Medicare-covered health Services you need (except hospice care for Members with Medicare Parts A and B and qualifying Clinical Trials) as long as you follow the Senior Advantage Plan's procedures on how to receive medical Services.

Coverage for Annuitants who are enrolling in conjunction with retirement

Coverage for Annuitants and their Dependents is effective on the first of the month following the first full calendar month of retirement income, provided the continuation form is submitted to the University of California Customer Service Center.

Coverage for Annuitants or Dependents becoming eligible for Medicare

Coverage will be transferred from the Kaiser Permanente Traditional Plan for non-Medicare enrollees to the Senior Advantage Plan for Medicare enrollees effective on the date determined by the carrier, based on processing the Senior Advantage Plan enrollment form through the Centers for Medicare & Medicaid Services (CMS).

Other situations

Coverage for Annuitants and their Dependents enrolling during a PIE is effective on the first day of the PIE, provided the enrollment form is received by the University of California Customer Service Center during the PIE. There is one exception to this rule: Coverage for a newly adopted child enrolling during the second PIE is effective on the date the adoption becomes final.

For Dependents who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment form is received by the University of California Customer Service Center.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

In order to change from individual to two-party coverage and from two-party to family coverage, you will need to obtain a change form from the University of California Customer Service Center, and complete and return it.

Notice to new enrollees about continuity of care

If you are currently receiving Services from a non-Plan Provider for an acute medical condition or an acute, serious, or chronic psychiatric condition and your enrollment with us will end coverage of the provider's Services, you may be eligible for temporary coverage of that non-Plan Provider's Services while your care is being transferred to us.

To qualify for this temporary coverage, all of the following criteria must be true:

- Your Health Plan coverage is in effect;
- You request this continuing coverage no later than 30 days after the effective date of coverage by calling our Member Service Call Center;
- You are receiving Services during a current episode of care for an acute medical condition or an acute, serious, or chronic psychiatric condition from a non-Plan Provider on the effective date of your Health Plan coverage;
- When you chose Health Plan, you were not offered other coverage that included an out-of-network option that would have covered the Services of your current non-Plan Provider;
- You did not have the option to continue with your previous Health Plan or to choose a Plan that covers the Services of your current non-Plan Provider;
- The non-Plan Provider agrees in writing to our standard contractual terms and conditions, including conditions pertaining to payment, and providing Services within our Service Area;
- The Services to be provided to you by the non-Plan Provider are Medically Necessary and would be covered Services under the terms of your Health Plan coverage, if provided by a Plan Provider; and
- Medical Group authorizes the care of your non-Plan Provider because Plan Providers are unable to maintain the continuity of your care.

To request this coverage or a copy of our coverage policy, please call our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

Dues

Members are entitled to health care coverage only for the period for which we have received the appropriate Dues from your Group. If you are responsible for any contribution to the Dues, your Group will tell you the amount and how you will pay it to your Group. In addition to any amount you must pay your Group, you must also continue to pay your monthly premiums to Medicare.

Note: If you were enrolled in Senior Advantage on December 31, 1998, without Medicare Part A entitlement, you may be eligible to purchase Medicare Part A from Social Security. Please contact the Social Security Administration for more information. If you become entitled to Medicare Part A, this may reduce the amount you would be expected to pay to your Group. Please check with your Group's Benefits Administrator.

Copayments and Coinsurance

You will pay out-of-pocket Copayments or Coinsurance for certain benefits. Copayments or Coinsurance are due when you receive the Service, but for items ordered in advance, you pay the Copayment or Coinsurance in effect on the order date (though we will not cover the item unless you still have coverage for it on the date you receive it). In some cases, we may agree to bill you for your Copayment. If we agree to bill you, we will increase the amount by $13.50 and mail you a bill for the entire amount.

Annual Out-of-Pocket Maximum

There is a limit to the total amount of Copayments and Coinsurance you must pay under this *DF/EOC* in a calendar year for the covered Services listed below. The limit is $1500 (for a Member) or $3000 (for an entire Family Unit). When you pay a Copayment or Coinsurance for these Services, ask for and keep the receipt. When the receipts add up to the annual Out-of-Pocket Maximum, please call our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** to find out where to bring your receipts. When you bring them in, we will give you a document to show that you do not have to pay any more Copayments or Coinsurance for these Services through the end of the calendar year.

Only the Copayments and Coinsurance you pay for these Services apply toward the Annual Out-of-Pocket Maximum:

- Ambulance Services;
- Amino acid-modified products used to treat congenital errors of amino acid metabolism;
- Diabetic testing supplies and equipment and insulin-administration devices;
- Home health care;
- Hospice care;
- Hospital care, including mental health inpatient care;
- Emergency Department, and In-Area and Out-of-Area Urgent Care visits;
- Imaging, laboratory, and special procedures;
- Office visits (including professional Services such as dialysis treatment, health education, and physical, occupational, and speech therapy);
- Outpatient surgery;
- Podiatric devices to prevent or treat diabetes-related complications;
- Prostheses and lymphedema wraps needed after a Medically Necessary mastectomy; and
- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx.

How to Obtain Services

Please read the following information carefully so that you will know from whom or which group of providers you may obtain health care.

As a Senior Advantage Plan Member, you are selecting our medical care program to provide your health care (except hospice care for Members with Medicare Parts A and B and Clinical Trials which are covered by Medicare). You must receive all covered care from Plan Providers inside our Service Area, except as described under the following headings:

- Emergency Care, Out-of-Area Urgent Care, and, Post-stabilization Care received from non-Plan Providers, in the "Emergency, Urgent, and Routine Care" section;
- "Getting a referral" in this "How to Obtain Services" section;
- "Our Visiting Member Program" in this "How to Obtain Services" section; and
- "Out-of-area dialysis care" in "Dialysis care" in the "Benefits" 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, and other benefits described in the "Benefits" section.

Using your identification card

Each Member's Health Plan ID card has a Medical Record Number on it, which is useful when you call for advice, make an appointment, or go to a provider for covered care. Your Medical Record Number is used to identify your medical records and Membership information. Your Medical Record Number should never change. Please let us know if we ever inadvertently issue you more than one Medical Record Number, or if you need to replace your ID card, by calling our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

Your ID card is for identification only. To receive covered Services, you must be a current Health Plan 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.

Your primary care Plan Physician

Your primary care Plan Physician plays an important role in coordinating your medical care needs, including hospital stays and referrals to specialists. You may select a primary care Plan Physician from any of our available Plan Physicians who practice in these specialties: internal medicine, obstetrics/gynecology, family practice, and pediatrics. You can also select a new primary care Plan Physician for any reason from any of our available Plan Physicians. To learn how to select a primary care Plan Physician, please call our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

Special note about Coachella Valley

Southern California Members. Subscribers residing in Coachella Valley are required to select a primary care Plan Physician (Affiliated Physician) for themselves and each covered Dependent. In this area, Plan Providers (except for Plan Pharmacies that are owned and operated by Kaiser Permanente) are referred to as "Affiliated Providers," for example "Affiliated Physicians" and "Affiliated Hospitals." Please refer to our "Service Area" description in "Section Three, General Information for All Members," for the ZIP codes that are in this area.

Your primary care Affiliated Physician will provide or arrange your care in this area, including Services from other Affiliated Providers, such as specialty Affiliated Physicians. **For Services from Affiliated Providers to be covered, your primary care Affiliated Physician must prescribe the care or authorize the referral,** except for annual mammograms and visits to your obstetrics/gynecology Affiliated Physician, which you can get directly without a referral from your primary care Affiliated Physician. Also, you may receive care from Plan Providers outside of Coachella Valley without a referral from your primary care Affiliated Physician (although some care requires a referral from a primary care Plan Physician, who need not be an Affiliated Physician; for more details see "Referrals to Plan Providers" in this "How to Obtain Services" section).

We will send the Subscriber a letter explaining how to select a primary care Affiliated Physician. If the Subscriber does not select a primary care Affiliated Physician, we will assign one. Dependents may select a different primary care Affiliated Physician from the Subscriber's by calling our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY).** You may change your primary care Affiliated Physician once a month.

If you need care before we have confirmed your primary care Affiliated Physician, please call our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7.a.m to 7 p.m., seven days a week** for assistance. To learn about Affiliated Providers, please refer to *Your Guidebook*.

If the Subscriber in your Family Unit does not live in Coachella Valley, you may receive covered care from Affiliated Providers in this area even if you haven't chosen a primary care Affiliated Physician.

Getting a referral

Referrals to Plan Providers

Primary Care Plan Physicians provide primary medical, pediatric, obstetrics, and gynecology care. Plan specialists provide specialty care in areas such as surgery, orthopedics, cardiology, oncology, urology, and dermatology. A Plan Physician will refer you to a Plan specialist when appropriate. However, you do not need a referral to receive primary care from Plan Physicians in the following areas: internal medicine, obstetrics, gynecology, family planning, family practice, pediatrics, optometry, psychiatry, and chemical dependency. Please check *Your Guidebook* to see if your facility has other departments that do not require a referral. Also, please refer to "Special note about Coachella

Valley, in this “How to Obtain Services” section for additional requirements that apply when a Subscriber lives in this area.

Medical Group authorization procedure for certain referrals

The following Services require prior authorization by Medical Group for the Services to be covered:

- **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 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 but not available from a Plan Provider.
- **Bariatric surgery.** If your Plan Physician makes a written referral for bariatric surgery, Medical Group’s Regional bariatric medical director or his or her designee will authorize the Service if he or she determines that it is Medically Necessary in accord with Medical Group’s bariatric surgery referral guidelines.
- **Durable medical equipment (DME).** If your Plan Physician prescribes DME, he or she will submit a written referral to the Plan Hospital’s DME Coordinator, who will authorize the DME if he or she determines that your DME coverage includes the item and that the item is listed on our formulary or is covered by Medicare for your condition. If the item doesn’t appear to meet our DME formulary or Medicare guidelines, then the DME Coordinator will contact the Plan Physician for additional information about the request. If the request still doesn’t appear to meet our DME formulary or Medicare guidelines, the request will be submitted to 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 DME formulary and Medicare guidelines, please refer to “Durable medical equipment” in the “Benefits” 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 the item is listed on our formulary or is covered by Medicare for your condition. If the item doesn’t appear to meet our soft goods formulary or Medicare guidelines, the coordinator will contact the Plan Physician for additional information about the request. If the request still doesn’t appear to meet our soft goods formulary or Medicare guidelines, the request will be submitted to 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” section.
- **Transplants.** If your Plan Physician makes a written referral for a transplant, 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, Medical Group will refer you to physician(s) at a transplant center, and Medical Group will authorize the Services if the transplant center's physician(s) determine that they are Medically Necessary.

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

The Copayments and Coinsurance for these referral Services are the same as those required for Services provided by a Plan Provider as described in the "Copayments and Coinsurance" section.

Medical Group's decision time frames. The applicable Medical Group designee will make the authorization decision within the time frame appropriate for your condition, but no later than five business days after receiving all 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 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, tests, or specialist that is needed and the date 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 Medical Group does not authorize all of the Services, you will be sent 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 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.

More information. This description is only a brief summary of the authorization procedure. For more information about 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 Medical Group), please call our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.** Please refer to the "Emergency, Urgent, and Routine Care" section for notification requirements that apply to Post-stabilization Care. Also, please refer to "Your primary care Plan Physician" in this "How to Obtain Services" section for the authorization requirements that apply when a Subscriber lives in Coachella Valley.

Second opinions

If you request a second opinion, it will be provided to you by an appropriately qualified health care professional. An appropriately qualified medical

professional is a physician who is acting within his or her scope of practice and who possesses the clinical background related to the illness or condition associated with the request for a second medical opinion. If you want a second opinion, some examples of when a second opinion is Medically Necessary are:

- If you are unsure about whether a procedure that has been recommended by your Plan Physician 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; or
- You have concerns about the diagnosis or plan of care.

You can either ask your Plan Physician to help you arrange for a second medical opinion, or you can make an appointment with another Plan Provider. If Medical Group determines that there isn't a Plan Provider who is an appropriately qualified medical professional for your condition, Medical Group will authorize a referral to a non-Plan Provider for a Medically Necessary second opinion. The Copayments and Coinsurance for these referral Services are the same as those required for Services provided by a Plan Provider as described in the "Copayments and Coinsurance" section.

If you have any questions, please call our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

Contracts with Plan Providers

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, including salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Providers are paid to provide or arrange medical and hospital care for Members, please ask your Plan Physician or call our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of noncovered Services or of Services you obtain from 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 so notify the Subscriber.

In addition, if you are undergoing treatment for a specific condition from a Plan Physician, or certain other providers, when the contract with him or her ends (for reasons other than medical disciplinary cause, criminal activity, or

the provider's voluntary termination), you may be eligible to continue receiving covered care from the terminated provider for your condition. The conditions that are subject to this continuation of care provision are:

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

The Services must otherwise be covered under this *DF/EOC.* Also, the terminated provider must agree in writing to our contractual terms and conditions and comply with them for Services to be covered by Medical Group. The Copayments and Coinsurance for the Services of a terminated provider are the same as those required for Services provided by a Plan Provider as described in the "Copayments and Coinsurance" section.

If you would like more information about this provision, or to make a request, please call our Member Service Call Center.

Our Visiting Member Program

If you visit the service area of another Region temporarily (not more than 90 days), you can receive certain Services from designated providers in that area. Coverage for these Services may differ from that in our Service Area, and is governed by our program for visiting members. This program does not cover certain Services, such as transplant or infertility Services. Also, except for covered Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care, your right to receive covered Services in the visited service area ends after 90 days unless you receive prior written authorization from us to continue receiving covered Services in the visited service area.

Please call our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week,** for more information about our Visiting Member Program, including facility locations in other service areas. The service areas and facilities where you may obtain visiting member Services may change at any time.

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 primary care 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.

Most 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, we have Member Service Call Center representatives, dedicated to assisting Medicare Members, available to assist

you. Please call our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.** For your convenience, you can also contact us through the member section of our Web site at *www.members.kp.org.*

Also, Member Service representatives at our Plan Facilities and Member Service Call 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 "Requests for Payment or Services" or with any issues in the "Dispute Resolution" section.

Plan Facilities

At most of our Plan Facilities, you can usually receive all 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.

Plan Hospitals and Plan Medical Offices

The following is a list of Plan Hospitals and most Plan Medical Offices in our Northern and Southern California Regions. Additional Plan Medical Offices are listed in *Your Guidebook*. 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 *DF/EOC* issued after that date. If we terminate a contract with a Plan Hospital, we will notify Subscribers who live in the hospital's area. If you have any questions about the current locations of Plan Facilities, please call our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

Plan Hospitals and Medical Centers (Plan Hospitals and Medical Offices)

All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week.

- Emergency Care is 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.
- 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).

Northern California Region:

City	Street Address
Fremont	Medical Center: 39400 Paseo Padre Parkway
Fresno	Medical Center: 7300 North Fresno Street
Hayward	Medical Center: 27400 Hesperian Boulevard
Oakland	Medical Center: 280 West MacArthur Boulevard
Redwood City	Medical Center: 1150 Veterans Boulevard
Richmond	Medical Center: 901 Nevin Avenue
Roseville	Medical Center: 1600 Eureka Road Plan Medical Offices: 1001 Riverside Avenue
Sacramento	Medical Center: 2025 Morse Avenue Medical Center: 6600 Bruceville Road Additional Plan Medical Offices: 2345 Fair Oaks Boulevard 1650 Response Road
San Francisco	Medical Center: 2425 Geary Boulevard
San Jose	Medical Center: 250 Hospital Parkway (Santa Teresa Medical Center)
San Rafael	Medical Center: 99 Montecillo Road Plan Medical Office: 1540 Fifth Avenue
Santa Clara	Medical Center: 900 Kiely Boulevard Plan Medical Offices: 1333 Lawrence Expressway
Santa Rosa	Medical Center: 401 Bicentennial Way
South San Francisco	Medical Center: 1200 El Camino Real
Stockton	Plan Hospital: 525 West Acacia Street (Dameron Hospital) Plan Medical Office: 7373 West Lane
Vallejo	Medical Center: 975 Sereno Drive
Walnut Creek	Medical Center: 1425 South Main Street Plan Medical Offices: 320 Lennon Lane Emergency Care is also available at Mount Diablo Medical Center: at 2540 East Street Concord, CA, which is a Plan Hospital only for Emergency Care

Plan Medical Offices in other cities

City	Street Address
Alameda	2417 Central Avenue
Antioch	3400 Delta Fair Boulevard 5601 Deer Valley Road
Campbell	220 East Hacienda Avenue
Clovis	2071 Herndon Avenue
Daly City	395 Hickey Boulevard
Davis	1955 Cowell Boulevard
Elk Grove	9201 Big Horn Boulevard

City	Street Address
Fairfield	1550 Gateway Boulevard
Folsom	2155 Iron Point Road
Gilroy	7520 Arroyo Circle
Livermore	3000 Las Positas Road
Manteca	1721 West Yosemite Avenue
Martinez	200 Muir Road
Milpitas	770 East Calaveras Boulevard
Modesto	4125 Bangs Avenue
Mountain View	555 Castro Street
Napa	3285 Claremont Way
Novato	97 San Marin Drive
Oakhurst	40595 WestLake Drive
Petaluma	3900 Lakeville Highway
Pleasanton	7601 Stoneridge Drive
Rancho Cordova	10725 International Drive
Rohnert Park	5900 State Farm Drive
San Bruno	901 El Camino Real
Selma	2651 Highland Avenue
Union City	3553 Whipple Road
Vacaville	3700 Vaca Valley Parkway

■ Locations in Stanislaus County

City	Street Address
Stanislaus County	Plan Hospital: 825 Delbon Avenue, Turlock (Emanuel Medical Center) Plan Medical Offices: 4125 Bangs Avenue, Modesto (Please refer to *Your Guidebook* for other Plan Providers in Stanislaus county)

Southern California Region:

City	Street Address
Anaheim	Medical Center: 441 North Lakeview Avenue Medical Center: 3033 West Orange Avenue (west Anaheim) Additional Plan Medical Offices: 1188 North Euclid Street 411 North Lakeview Avenue

City	Street Address
Bakersfield	Plan Hospital: 420 34th Street (Memorial Hospital) Plan Hospital: 2215 Truxtun Avenue (Mercy Hospital) Plan Hospital: 300 Old River Road (Mercy Southwest Hospital) Plan Medical Offices: 3700 Mall View Road 8800 Ming Avenue 3501 Stockdale Highway 1200 Discovery Drive
Baldwin Park	Medical Center: 1011 Baldwin Park Boulevard
Bellflower	Medical Center: 9400 East Rosecrans Avenue
Escondido	Plan Hospital: 555 East Valley Parkway (Palomar) Plan Medical Office: 732 North Broadway Street
Fontana	Medical Center: 9961 Sierra Avenue
Harbor City	Medical Center: 25825 South Vermont Avenue
Irvine	Plan Hospital: 16200 Sand Canyon Avenue (Irvine Regional Hospital) Plan Medical Office: 6 Willard Street
Lancaster	Plan Hospital: 1600 West Avenue J (Antelope Valley Hospital) Plan Hospital: 43830 North 10th Street West (Lancaster Community Hospital) Plan Medical Office: 43112 North 15th Street West
Los Angeles	Medical Center: 1526 North Edgemont Street Medical Center: 6041 Cadillac Avenue (west LA) Additional Plan Medical Offices: 5220 Telford Street (east LA) 5119 Pomona Boulevard (east LA) 12001 West Washington Boulevard (Culver Marina Medical Offices)
Panorama City	Medical Center: 13652 Cantara Street
Riverside	Medical Center: 10800 Magnolia Avenue
San Diego	Medical Center: 4647 Zion Avenue Additional Plan Medical Offices: 7060 Clairemont Mesa Boulevard 4650 Palm Avenue 3250 Fordham Street 3420 Kenyon Street 3250 Wing Street 11939 Rancho Bernardo Road 4405 Vandever Avenue
Woodland Hills	Medical Center: 5601 De Soto Avenue

Plan Medical Offices in other cities

City	Street Address
Aliso Viejo	24502 Pacific Park Drive
Bonita	3955 Bonita Road
Brea	1900 East Lambert Road
Carlsbad	6860 Avenida Encinas
Chino	11911 Central Avenue
Claremont	250 West San Jose Street
Colton	789 South Cooley Drive
Corona	2055 Kellogg Avenue
Cudahy	7825 Atlantic Avenue
Culver City	5620 Mesmer Avenue
Downey	9449 East Imperial Highway
El Cajon	1630 East Main Street 250 Travelodge Drive
Garden Grove	12100 Euclid Street
Gardena	15446 South Western Avenue
Glendale	444 West Glenoaks Boulevard
Huntington Beach	18081 Beach Boulevard
Inglewood	110 North La Brea Avenue
La Mesa	8080 Parkway Drive and 3875 Avocado Boulevard
La Palma	5 Centerpointe Drive
Long Beach	3900 East Pacific Coast Highway
Mission Viejo	23781 Maquina Avenue
Montebello	1550 Town Center Drive
Moreno Valley	12815 Heacock Street
Ontario	1025 West "I" Street
Pasadena	450 North Lake Avenue
Rancho Cucamonga	10850 Arrow Route
Redlands	25828 Redlands Boulevard
San Bernardino	1717 Date Place
San Dimas	1255 West Arrow Highway
San Juan Capistrano	30400 Camino Capistrano
Santa Ana	3401 South Harbor Boulevard 1900 East 4th Street
Santa Clarita	27107 Tourney Road
Simi Valley	3900 Alamo Street
Thousand Oaks	365 East Hillcrest Drive and 145 Hodencamp Road
Victorville	14011 Park Avenue
Vista	780 Shadowridge Drive
West Covina	1249 Sunset Avenue
Whittier	12470 Whittier Boulevard
Wildomar	36450 Inland Valley Drive
Yorba Linda	22550 East Savi Ranch Parkway

Affiliated Plan Hospitals

Coachella Valley	• Desert Regional Medical Center at 1150 North Indian Canyon Drive, Palm Springs, CA • Eisenhower Medical Center at 39000 Bob Hope Drive, Rancho Mirage, CA • Hi-Desert Medical Center at 6601 White Feather Road, Joshua Tree, CA • John F. Kennedy Memorial Hospital at 47111 Monroe Street, Indio, CA

For information about receiving care in this area, see the "Special note about Coachella Valley" in the "How to Obtain Services" section. Also, please refer to *Your Guidebook* for this area for other Plan Providers, including Affiliated Plan Physicians and Pharmacies.

Your Guidebook

Plan Medical Offices and Plan Hospitals for your area are also 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, and includes a detailed telephone directory for appointments and advice. *Your Guidebook* provides other important information, such as your Member rights and responsibilities. It is subject to change and periodically updated. You can get a copy by calling our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week**, or log on to *www.members.kp.org.*

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 Call 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.

Emergency, Urgent, and Routine Care

This section explains how to obtain covered Emergency Care, urgent care, Post-stabilization Care, and routine care. It also describes how our advice nurses can help assess nonemergency medical symptoms.

The care discussed in this section is not covered unless it meets the coverage requirements stated in the "Benefits" section (subject to the "Exclusions, Limitations, and Reductions" section.

Emergency Care

If you have an Emergency Medical Condition, call 911 or go to the nearest hospital. When you have an Emergency Medical Condition, we cover Emergency Care from Plan Providers and non-Plan Providers anywhere in the world. An Emergency Medical Condition is:

- A medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in any of the following:
  - serious jeopardy to your health;
  - serious impairment to your bodily functions; or
  - serious dysfunction of any bodily organ or part.
- "Active labor," which means a labor when there is inadequate time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the Member or unborn child.

Note: Emergency Care is available at Plan Hospital Emergency Departments listed in *Your Guidebook*. For ease and continuity of care, we encourage you to go to a Plan Hospital Emergency Department, but only if it is reasonable to do so, considering your condition or symptoms. Please refer to *Your Guidebook* for Plan Hospital Emergency Department locations in your area.

Urgent care

When you are sick or injured, you may have an urgent care need. 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 nurse telephone number at a Plan Facility. Please refer to *Your Guidebook* for advice nurse and Plan Facility telephone numbers.

Also, in the event of unusual circumstances that delay or render impractical the provision of Services under this *DF/EOC* (such as, major disaster, epidemic, war, riot, and civil insurrection), we cover urgent care inside our Service Area from a non-Plan Provider.

Out-of-Area Urgent Care

If you are temporarily outside our Service Area for six months or less, and have an urgent care need due to an unforeseen illness or injury, we cover the Medically Necessary Services you receive from a non-Plan Provider if we find that the Services were necessary to prevent serious deterioration of your health and they could not be delayed until you returned to our Service Area.

Post-stabilization and follow-up care

Post-stabilization Care is the Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable, or after you obtain covered Out-of-Area Urgent Care. We cover Post-stabilization Care if one of the following is true:

- We provide or authorize the care;
- The care was Medically Necessary to maintain stabilization and it was administered within one hour following a request for authorization and we have not yet responded;
- The non-Plan Provider and we do not agree about your care and a Plan Physician is not available for consultation; or
- In the rare circumstance that we are unavailable or cannot be contacted.

Covered Post-stabilization Care is effective until one of the following events occur:

- You are discharged from the non-Plan Hospital;
- We assume responsibility for your care; or
- The non-Plan Provider and we agree to other arrangements.

To request authorization to receive Post-stabilization Care from a non-Plan Provider, you must call us toll free at **1-800-225-8883** *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 your Post-stabilization 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 with the treating physician's concurrence. If we decide to have a Plan Provider (or other designated 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 transportation) we have authorized since we do not cover unauthorized Post-stabilization Care provided by non-Plan Providers, except as otherwise described in this section. Also, you will only be held financially liable if you are notified by the non-Plan Provider or us about your potential liability.

Follow-up care. We do not cover follow-up care provided by non-Plan Providers unless it is covered Emergency Care, Out-of-Area Urgent Care, or Post-stabilization Care described in this "Emergency, Urgent, and Routine Care" section.

Call us!

You must call us toll free at **1-800-225-8883** (or the notification telephone number on your ID card) to request authorization for Post-stabilization Care *before* you obtain the care from a non-Plan Provider if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible). Also, please call us any time you are admitted to a non-Plan Hospital.

We understand that extraordinary circumstances can delay your ability to call us, for example, if you are unconscious or a young child without a parent or guardian present. In these cases, you must call us as soon as reasonably possible. Please keep in mind that anyone can call us for you. Except as otherwise described in this section, we do not cover any care you receive from non-Plan Providers after you're Clinically Stable 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.

Payment and reimbursement

If you receive Emergency Care, Out-of-Area Urgent Care, or Post-stabilization Care from a non-Plan Provider, the provider may agree (or may be required) to bill for the Services or may require that you pay for the Services at that time. In either case, to request payment or reimbursement, you must file a claim as described under "Non-Plan Emergency Care, Out-of-Area Urgent Care, and Out-of-Area Dialysis Care" in the "Requests for Payment or Services" section.

We will reduce any payment we make by applicable Copayments or Coinsurance, which are the same ones required for Services provided by a Plan Provider as described in the "Copayments and Coinsurance" section.

Also, if Medicare is secondary payer by law, we will reduce our payment by any amounts paid or payable (or that in the absence of this Plan would have been payable) for the Services under any insurance policy, or any other contract or coverage, or any government program except Medicaid.

Routine care

If you need to make a routine care appointment, please refer to *Your Guidebook* for appointment telephone numbers, or log on to *www.members.kp.org* to request an appointment online. Routine appointments are for medical needs that aren't urgent (such as routine checkups and school physicals). Try to make your routine care appointments as far in advance as possible.

Our advice nurses

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. Whether you are calling for advice or to make an appointment, you can speak to an advice nurse. They can often resolve a minor concern or advise you about what to do next, including making a same-day urgent care appointment for you if it's medically appropriate. To reach an advice nurse, please refer to *Your Guidebook* for the telephone numbers.

Benefits

The Services described in this Senior Advantage Plan "Benefits" section are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary.
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except where specifically noted to the contrary in the following sections about:
  - Our Visiting Member Program, in the "How to Obtain Services" section; and
  - Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care received from non-Plan Providers, in the "Emergency, Urgent, and Routine Care" section.
- You receive the Services from Plan Providers inside our Service Area, except where specifically noted to the contrary in the following sections about:
  - Getting a referral, in the "How to Obtain Services" section;
  - Our Visiting Member Program, in the "How to Obtain Services" section;
  - Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care received from non-Plan Providers, in the "Emergency, Urgent, and Routine Care" section; and
  - Out-of-area dialysis care, in this "Benefits" section.

Exclusions and limitations that apply only to a particular benefit are described in this "Benefits" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Exclusions, Limitations, and Reductions" section. Also, please refer to:

- The "Emergency, Urgent, and Routine Care" section for information about how to obtain Emergency Care, urgent care, Post-stabilization Care, and routine care;
- The "Copayments and Coinsurance" section for the amounts you must pay for covered Services described in this "Benefits" section; and
- *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.

■ Special note about services associated with Clinical Trials

Original Medicare will pay for certain Services related to qualifying Clinical Trials. **This is not covered by us.** You should continue to come to Plan Providers for all covered Services that are not part of the Clinical Trial. Medicare will pay for many, but not all, Services associated with qualifying Clinical Trials. You should ask the Clinical Trial provider if the clinical trial qualifies for Medicare payments and what Medicare Coinsurance and other out-of-pocket expenses you will have to pay for related Services. Original Medicare does not require that you get a referral from a Plan Physician to join a qualifying Clinical Trial. However, you should tell us before you join a clinical trial outside of Kaiser Permanente so we

can keep track of your Services. For more information on Medicare payments for Clinical Trials and which trials qualify, please call Medicare directly toll free at **1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048).**

Hospital inpatient care

We cover the following inpatient Services in a Plan Hospital when the Services are generally and customarily provided by acute care general hospitals in our Service Area. There is a charge of **$250 per hospital inpatient admission.**

- Room and board, including a private room, if Medically Necessary;
- Specialized care and critical care units;
- General and special prescribed nursing care;
- Operating and recovery rooms;
- Plan Physicians' and surgeons' Services, including consultation and treatment by specialists;
- Anesthesia;
- Medical supplies;
- Blood, blood products, and their administration;
- Obstetrical care and delivery (including cesarean section);

  Note: If you are discharged within 48 hours after delivery (or 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.
- Respiratory therapy; and
- Medical social Services and discharge Planning.

The following types of inpatient Services are covered only as described under these headings in this Senior Advantage Plan "Benefits" section:

- "Chemical dependency Services"
- "Dental Services for radiation treatment and dental anesthesia"
- "Dialysis care"
- "Drugs, supplies, and supplements"
- "Durable medical equipment (DME)"
- "Hospice care"
- "Imaging, laboratory, and special procedures"
- "Infertility Services"
- "Mental health Services"
- "Ostomy and urological supplies"
- "Physical, occupational, and speech therapy and multidisciplinary rehabilitation Services"
- "Prosthetic and orthotic devices"
- "Reconstructive surgery"
- "Religious Nonmedical Health Care Institution Services"
- "Skilled Nursing Facility care"
- "Transplant Services"

Outpatient care

We cover the following outpatient care for preventive medicine, diagnosis, and treatment at **$10 per visit:**

- Primary care visits for internal medicine, gynecology (cervical cancer screening tests and mammograms are included with the office visit Copayment or Coinsurance), family practice, and pediatrics;

- Specialty care visits (refer to "Referrals to Plan Providers" in the "How to Obtain Services" section for information about referrals to Plan specialists);
- Allergy testing;
- Outpatient surgery;
- Respiratory therapy visits; and
- Physical examinations and preventive health screenings, such as screening and tests for colorectal cancer in accord with Medicare guidelines when prescribed by a Plan Physician: X-rays, sigmoidoscopy, and stool tests. For Members age 50 and over, who are not at high risk of developing colon cancer, Medicare covers colonoscopy every 10 years or no sooner than four years after a sigmoidoscopy. You should consult with your Plan Physician to determine what is appropriate for you.

We cover the following outpatient care at **$3 per visit:**

- Allergy injections.

We cover the following outpatient care at **no charge:**

- Blood, blood products, and their administration;
- Medical social Services;
- After confirmation of pregnancy, all Obstetrical Department prenatal visits and the first postpartum visit;
- Scheduled well-child preventive care visits (age 23 months or younger); and
- House calls within our Service Area when care can best be provided in your home as determined by a Plan Physician.

Note: Emergency Department visits (please refer to the "Emergency, Urgent, and Routine Care" section for information about Emergency Care and urgent care).

Emergency Care: $50 per visit*

Out-of-Area Urgent Care: $50 per visit*

* Waived if admitted to the hospital within 24 hours for the same condition.

The following types of outpatient Services are covered only as described under these headings in this Senior Advantage Plan "Benefits" section:

- "Chemical dependency Services"
- "Dental Services for radiation treatment and dental anesthesia"
- "Dialysis care"
- "Drugs, supplies, and supplements"
- "Durable medical equipment (DME)"
- "Family Planning Services"
- "Health education"
- "Hearing Services"
- "Home health care"
- "Hospice care"
- "Imaging, laboratory, and special procedures"
- "Infertility Services"
- "Mental health Services"
- "Ostomy and urological supplies"
- "Physical, occupational, and speech therapy, and multidisciplinary rehabilitation Services"
- "Prosthetic and orthotic devices"

- "Reconstructive surgery"
- "Transplant Services"
- "Vision Services"

Northern California Medicare Members:

- Manual manipulation of the spine to correct subluxation, as covered by Medicare, is provided when prescribed by a Plan Physician and performed by a Plan osteopath or chiropractor.

Southern California Medicare Members:

- Manual manipulation of the spine to correct subluxation, as covered by Medicare, is provided by a participating chiropractor of the American Specialty Health Plans of California, Inc. (ASH Plans). A referral by a Plan Physician is not required. For the list of participating ASH Plans providers, please refer to your ASH Plans provider directory. To request an ASH Plans provider directory, call our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

Ambulance Services

Emergency

When you have an Emergency Medical Condition, we cover emergency Services of a licensed ambulance at **no charge.** We cover emergency ambulance Services that are not ordered by us only if one of the following is true:

- Your treating physician determines that you must be transported to another facility when you are not Clinically Stable because the care you need is not available at the treating facility; or
- You are not already being treated, and you reasonably believe that your condition requires ambulance transportation.

Nonemergency

We also cover nonemergency ambulance Services for transportation at **no charge** if your condition meets Medicare guidelines.

■ Ambulance Services exclusion

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

Chemical dependency Services

Inpatient detoxification

We cover hospitalization in a Plan Hospital only for medical management of withdrawal symptoms, including dependency recovery Services, education, and counseling. There is a charge of **$250 per hospital inpatient admission.**

Outpatient

We cover the following Services for treatment of chemical dependency:

- Day treatment programs;
- Intensive outpatient programs;
- Medical treatment for withdrawal symptoms; and
- Counseling for chemical dependency.

  $10 per individual therapy visit

  $5 per group therapy visit

- We cover methadone maintenance treatment at **no charge** for pregnant Members during pregnancy and for

two months after delivery at a licensed treatment center approved by Medical Group. We do not cover methadone maintenance treatment in any other circumstances.

Transitional residential recovery Services

We cover up to 60 days per calendar year of chemical dependency treatment in a nonmedical transitional residency recovery setting approved in writing by Medical Group at **$100 per admission;** no more than 120 days of covered care is provided in any five-consecutive-calendar-year period. These settings provide counseling and support Services in a structured environment.

■ Chemical dependency Services exclusions

- Services in a specialized facility for alcoholism, drug abuse, or drug addiction, except as described above.

Dental Services for radiation treatment

Dental Services for radiation treatment

We cover Services covered by Medicare, including evaluation, extraction, dental X-rays, and fluoride treatment, if a Plan Physician refers you to a dentist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a referral" in the "How to Obtain Services" section) to prepare your jaw for radiation treatment of cancer.

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 is true:

- You are under age seven, 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; and
- 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.

Inpatient care: $250 per admission

Outpatient care: $10 per visit

Dialysis care

We cover dialysis Services related to acute renal failure and end-stage renal disease (ESRD) if the following conditions are met:

- You satisfy all the medical criteria developed by Medical;
- The facility is certified by Medicare; and
- A Plan Physician provides a written referral for your dialysis treatment.

Inpatient care: $250 per admission

Outpatient care: $10 per visit

Dialysis treatment: No charge

We also cover peritoneal home dialysis (including equipment, training, and medical supplies) at **no charge.**

■ Out-of-Area dialysis care

We cover dialysis for Members with end-stage renal disease (ESRD) at a Medicare-certified facility that is needed while you are traveling temporarily outside our Service Area. There is no limit to the number of covered routine

dialysis days. Although it is not required, we ask that you contact us before you leave our Service Area so we can coordinate your care when you are temporarily outside our Service Area. Please refer to your ESRD patient material for more information.

Note: The procedure for obtaining reimbursement for Out-of-Area dialysis care is described in the "Requests for Payment or Services" section.

Drugs, supplies, and supplements

We cover drugs, supplies, and supplements specified in this section and drugs covered by Medicare at **no charge** when prescribed by a Plan Physician (except as otherwise described under "Outpatient drugs, supplies, and supplements") and in accord with our drug formulary guidelines.

You must obtain covered drugs, supplies, and supplements from a Plan Pharmacy. Please refer to *Your Guidebook* for the location of Plan Pharmacies in your area. You may be able to order refills through our Web site at *www.members.kp.org.* A Plan Pharmacy or *Your Guidebook* can give you more information about obtaining refills (for example, most Plan Pharmacies offer refills by mail, whereas a few Plan Pharmacies don't dispense covered refills).

Note: Durable medical equipment (DME) used to administer drugs is not covered under this section (instead, refer to the "Durable medical equipment (DME)" section).

■ Administered drugs and self-administered IV drugs

Administered drugs, supplies, and supplements. We cover the following at **no charge** during a covered stay in a Plan Hospital or Skilled Nursing Facility, or if they require administration or observation by medical personnel and are administered to you in a Plan Medical Office or during home visits:

- Drugs, injectables, internally implanted time-release contraceptives, intrauterine devices (IUDs), emergency contraceptive pills, radioactive materials used for therapeutic purposes, vaccines and immunizations approved for use by the federal Food and Drug Administration (FDA), and allergy test and treatment materials.

Self-administered IV drugs, supplies, and supplements. We cover certain drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as IV or intraspinal-infusion) at **no charge.** We also cover the supplies and equipment required for their administration. Injectable drugs, insulin, and drugs for the treatment of infertility are not covered under this paragraph (instead, refer to the "Outpatient drugs, supplies, and supplements" paragraph below).

■ Diabetes urine-testing supplies and certain insulin administration devices

We cover the following diabetes urine-testing supplies:

- Ketone test strips and sugar or acetone test tablets or tapes at **no charge.**

Note: Diabetes blood-testing equipment and their supplies are not covered under this "Drugs, supplies, and supplements" section (instead, refer to the "Durable medical equipment (DME)" section).

We cover the following insulin-administration devices:

- Disposable needles and syringes, pen delivery devices, and visual aids required to ensure proper dosage (except eyewear) at **$10 generic/$20 brand name per prescription for up to a 100-day supply.**

Note: Insulin pumps and their supplies are not covered under this "Drugs, supplies, and Supplements" section (instead, refer to the "Durable medical equipment (DME)" section).

Outpatient drugs, supplies, and supplements

We cover the following drugs, supplies, and supplements when prescribed by a Plan Physician or dentist. (Drugs, supplies, and supplements prescribed by dentists are not covered if a Plan Physician determines that they are not Medically Necessary.) We cover at **$10 generic/$20 brand name per prescription for up to a 100-day supply:**

- 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.
- Smoking-cessation drugs are covered if you participate in a Plan-approved behavior intervention program.
- Diaphragms, cervical caps, and oral contraceptives.
- Disposable needles and syringes needed for injecting covered drugs.

Note: You will pay the Copayment or Charges, whichever is less.

We cover drugs for the treatment of sexual dysfunction disorders as follows:

- Episodic drugs, as prescribed by a Plan Physician, will be provided up to a maximum of 27 doses in any 100-day period at **50 percent Coinsurance.**
- Maintenance (nonepisodic) drugs, as prescribed by a Plan Physician, that require doses at regulated intervals will be provided at **50 percent Coinsurance for up to a 100-day supply.**

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 comprised 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 information about whether a particular drug is included in our drug formulary, please call our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.** The presence of a drug on our drug formulary does not necessarily mean that

your Plan Physician will prescribe it for a particular condition.

Our drug formulary guidelines allow you to obtain nonformulary prescription drugs (those not listed on our drug formulary for your condition) if 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 Plan-approved behavioral intervention program for specific conditions, and you may be required to pay for the program.

Drugs, supplies, and supplements exclusions

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

Note: If this *DF/EOC* is amended to exclude a drug that we have been covering and providing to you under this *DF/EOC*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the FDA. You must pay a **50 percent Coinsurance.**

Durable medical equipment (DME)

We cover durable medical equipment (DME) at **no charge** in accord with our DME formulary and Medicare guidelines. Coverage is limited to the standard item of equipment that adequately meets your medical needs.

DME at a Plan Hospital or Skilled Nursing Facility

We cover equipment, including oxygen used during a covered stay in a Plan Hospital or Skilled Nursing Facility, if Skilled Nursing Facilities ordinarily furnish the equipment.

DME for home use

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.

Inside our Service Area, we cover DME for use in your home (or another location used as your home defined by Medicare inside our Service Area). If you live outside our Service Area, we do not cover most DME for use in your home, but our DME formulary guidelines allow certain DME (such as crutches and canes) for use in your home to be picked up from Plan Facilities even if you live outside our Service Area. To find out whether we will cover a particular DME item even if you live outside our Service Area, please call our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.** References in this paragraph to living outside our

Service Area only apply to Members enrolled in Senior Advantage on December 31, 1998, who lived outside our Service Area and continue to live at the same address.

We decide whether to rent or purchase the equipment, and we select the vendor. We will repair or replace the equipment, unless the repair or replacement is due to misuse.

About our DME formulary

Our DME formulary includes the list of durable medical equipment that is covered by Medicare or has been approved by our DME Formulary Review Committee for our Members. The DME formulary was developed by a multidisciplinary clinical and operational workgroup with review and input from Plan Physicians and medical professionals with DME expertise (for example physical, respiratory, and enterostomal therapists and home health). A multidisciplinary DME Formulary Review Committee is responsible for reviewing and revising the DME formulary. The DME formulary is periodically updated to keep pace with changes in medical technology, Medicare guidelines, and clinical practice. To find out whether a particular DME is included in our DME formulary, please call our Member Service Call Center.

Our formulary guidelines allow you to obtain nonformulary DME (those not listed on our DME formulary for your condition) if 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".

Note: Diabetes urine-testing supplies and insulin-administration devices (except insulin pumps) are not covered under this "Durable medical equipment (DME)" section (instead, refer to the "Drugs, supplies, and supplements" section). This section does apply to the following diabetes blood-testing equipment and insulin-administration devices:

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

Durable medical equipment exclusions

- Comfort, convenience, or luxury equipment or features;
- Exercise or hygiene equipment;
- Dental appliances;
- Nonmedical items such as sauna baths, whirlpools, or elevators;
- Modifications to your home or car;
- Electronic monitors of the heart or lungs, except infant apnea monitors; or
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies, such as blood glucose monitor test strips, lancets, and lancet devices).

Family planning Services

We cover:

- Family planning counseling, including preabortion and

postabortion counseling, and information on birth control;

- Tubal ligations;
- Vasectomies; and
- Voluntary termination of pregnancy.

Inpatient Services: $250 per hospital inpatient admission

Outpatient visits: $10 per visit

Note: Contraceptive drugs and devices are not covered under this "Family planning Services" section (instead, refer to "Drugs, supplies, and supplements" in this "Benefits" section).

Health education

We cover a variety of health education programs to help you protect and improve your health, including programs for smoking cessation, stress management, and chronic conditions (such as diabetes and asthma). You can also participate in programs and classes that we don't cover, which may require that you pay a fee. For more information about our health education programs, please contact your local Health Education Department or call our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week,** or log on to *www.members.kp.org*. *Your Guidebook* also includes information about our health education programs.

Individual office visit: $10 per visit

All other covered Services: No charge

Note: In accord with Medicare guidelines, any diabetes self-management training courses, accredited by the American Diabetes Association, may be available to you if you receive a referral from a Plan Physician.

Hearing Services

Hearing tests. We cover hearing tests to determine the need for hearing correction and to determine the most appropriate hearing aid at **$10 per visit.**

Hearing aid(s). We cover the following:

- A hearing aid (up to an allowance of **$2,500 per ear**) for each ear and a replacement hearing aid for each ear after 36 months when prescribed by a Plan Physician or Plan audiologist. Also, the allowance can only be used at the initial point of sale. If you do not use all of your allowance at the initial point of sale, you cannot use it later. We will cover two hearing aids only if both are required to provide significant improvement that is not obtainable with only one hearing aid;
- Visits to verify that the hearing aid conforms to the prescription; and
- Visits for fitting, counseling, adjustment, cleaning, and inspection after the warranty is exhausted.

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

■ Hearing Services exclusions

- Replacement parts and batteries;
- Replacement of lost or broken hearing aids,
- Repair of hearing aids after the warranty period;
- Internally implanted hearing aids;
- Comfort, convenience, or luxury equipment or features; and

- Hearing aids prescribed or ordered before the effective date or after the termination date of your coverage.

Home health care

Home health care means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. We cover part-time or intermittent home health Services in accord with Medicare guidelines at **no charge** if all of the following are true:

- You are substantially confined to your home;
- Your condition requires the Services of a nurse, physical therapist, or speech therapist;
- A Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home;
- The Services are provided inside our Service Area, and
- The Services are covered by Medicare, such as part-time or intermittent skilled nursing care and part-time or intermittent service of a home health aide.

The following types of Services are covered in the home only as described under these headings in this "Benefits" section:

- "Dialysis care"
- "Drugs, supplies, and supplements"
- "Durable medical Equipment (DME)"
- "Ostomy and urological supplies"
- "Physical, occupational, and speech therapy and multidisciplinary rehabilitation Services"
- "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; and
- 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 Services listed below only if all of the following requirements are met:

- You are not entitled to Medicare Part A;
- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less;
- The Services are provided inside our Service Area by a licensed hospice

agency approved by Medical Group; and

- 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 at **no charge,** 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 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 Call Center for the current list of these drugs.
- Durable medical equipment.
- Respite care, which is occasional short-term inpatient care limited to no more than five consecutive days at a time, when necessary to relieve your caregivers.
- 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; and
  - short-term inpatient care required at a level that cannot be provided at home.

Special note for Members with Medicare Parts A and B

Medicare covers hospice care directly for Members with Medicare Parts A and B; **we do not cover the care.** Although we do not cover it, if your Plan Physician determines you are eligible for and you wish to elect hospice care, we will assist you in identifying Medicare-certified hospices, including any Kaiser Permanente hospice, in your area. The hospice will bill Medicare directly for the care ordered by the hospice team. In addition, the hospice may charge you 5 percent of the reasonable cost of outpatient drugs or biologicals for pain relief and symptom management (up to a maximum of $5 for each prescription). The hospice may also charge you approximately $5 for each day of inpatient respite care.

Note: If you elect hospice care, you are not entitled to any other benefits for the terminal illness under this *DF/EOC* or Medicare. However, we will continue to

cover the Services described in this *DF/EOC* that are not related to the terminal illness. You may change your decision to receive hospice care at any time.

Imaging, laboratory, and special procedures

We cover the following Services at **no charge** only when prescribed as part of care covered under other parts of this "Benefits" section (for example, diagnostic imaging and laboratory tests are covered for infertility only to the extent that infertility Services are covered under "Infertility Services"):

- Annual mammograms for women age 40 and over (no referral required);
- Diagnostic and therapeutic imaging, such as X-rays, magnetic resonance imaging (MRI), computed tomography, and positron emission tomography;
- Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available;
- Special procedures such as electrocardiograms and electroencephalograms; and
- Ultraviolet light treatment; and

Infertility Services

We cover the following Services:

- Services for diagnosis and treatment of involuntary infertility.
- Artificial insemination (except for donor semen or eggs and Services related to their procurement and storage).

  Inpatient Services: $250 per visit

  Outpatient Services: $10 per visit

Note:

- Diagnostic procedures are not covered under this "Infertility Services" section (instead, refer to "Imaging, laboratory, and special procedures" in this "Benefits" section).
- Drugs related to the diagnosis and treatments of involuntary infertility are not covered under this "Infertility Services" section (instead, refer to "Drugs, supplies, and supplements" in this "Benefits" section).

■ Infertility Services exclusions

Services to reverse voluntary, surgically induced infertility are not covered.

Mental health Services

We cover mental health Services as specified below, except that any inpatient-day limits specified below do not apply to the following conditions:

- These severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.
- A Serious Emotional Disturbance (SED) of a child under 18, which means mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child

also meets at least one of the following three criteria:

- as a result of the mental disorder, 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 either (a) the child is at risk of removal from 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; or
- 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.

For all other mental health conditions, we cover mental health Services in accord with Medicare guidelines and coverage is limited to treatment for psychiatric conditions that are amenable to active treatment, and for which active treatment provides a reasonable prospect of improvement or maintenance at a functional level.

Outpatient mental health Services

We cover:

- Diagnostic evaluation and psychiatric treatment;
- Individual and group therapy visits;
- Prescribed psychological testing; and
- Visits for the purpose of monitoring drug therapy.

Individual office visits: $10 per visit

Group therapy visits: $5 per visit

Inpatient psychiatric care

We cover up to 190 days per lifetime for acute psychiatric conditions in a Medicare-certified psychiatric hospital. The number of covered lifetime hospitalization days is reduced by the number of inpatient days for mental health treatment previously covered by Medicare in a psychiatric hospital. After you exhaust these lifetime days, we cover additional days when prescribed by a Plan Physician. There is a charge of **$250 per hospital inpatient admission.**

Hospital alternative Services

We cover treatment in a structured multidisciplinary program as an alternative to inpatient psychiatric care. Hospital alternative Services include partial hospitalization and treatment in an intensive outpatient psychiatric treatment program.

Note: Drugs, supplies, and supplements are not covered under this "Mental health Services" section (instead, refer to "Drugs, supplies, and supplements" in this "Benefits" section).

Ostomy and urological supplies

Inside our Service Area, we cover ostomy and urological supplies at **no charge** prescribed in accord with our soft goods formulary and Medicare guidelines.

We select the vendor and coverage is limited to the standard item of equipment that adequately meets your medical needs.

About our soft goods formulary

Our soft goods formulary includes the list of ostomy and urological supplies that are covered by Medicare or have been approved by our Soft Goods Formulary Review Committee for our Members. Our Soft Goods Formulary Review Committee is responsible for reviewing and revising the soft goods formulary. The soft goods formulary is periodically updated to keep pace with changes in medical technology, Medicare guidelines, 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 Call 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 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.

Ostomy and urological supplies exclusions

Comfort, convenience, or luxury equipment or features.

Physical, occupational, and speech therapy, and multidisciplinary rehabilitation Services

Physical, occupational, and speech therapy

In accord with Medicare guidelines, we cover initial and subsequent courses of physical, occupational, and speech therapy in a Plan Facility or Skilled Nursing Facility, or as part of home health care, if in the judgment of a Plan Physician:

- Significant improvement is expected within a reasonable and generally predictable period, or
- The therapy is necessary to establish a maintenance program required in connection with certain medical conditions.

Inpatient Services: No charge

Outpatient visits: $10 per visit

Limitations

- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.

Multidisciplinary rehabilitation

If, in the judgment of a Plan Physician, continuing significant improvement in function is achievable within a reasonable and generally predictable period, we will cover treatment in accord with Medicare guidelines in an organized, multidisciplinary rehabilitation program in a Plan Facility or Skilled Nursing Facility.

Inpatient Services: $250

Outpatient visits: $10 per visit

Prosthetic and orthotic devices

We cover the devices listed below if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is not ill or injured. Also, coverage is provided only in our Service Area and limited to the standard device that adequately meets your medical needs. We also cover

enteral formula for Members who require tube feeding in accord with Medicare guidelines.

We select the provider or vendor that will furnish the covered device. Coverage includes fitting and adjustment of these devices, their repair or replacement, and Services to determine whether you need a prosthetic or orthotic device. If we do not cover the device, we try to help you find facilities where you may obtain what you need at a reasonable price.

■ Internally implanted devices

We cover at **no charge** internal devices implanted during covered surgery, such as pacemakers and hip joints, that are approved by the federal Food and Drug Administration for general use and are covered by Medicare.

■ External devices

We cover the following external prosthetics and orthotics at **no charge:**

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (including electronic voice-producing machines) covered by Medicare;
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary;
- Prosthetics and orthotics that are covered by Medicare, including therapeutic footwear for severe diabetes-related foot disease in accord with Medicare guidelines;
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan podiatrist, physiatrist, or orthopedist;
- Compression burn garments and lymphedema wraps and garments; and
- 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; and
  - Special footwear for foot disfigurement due to disease, injury, or developmental disability.

■ Prosthetic and orthotic devices exclusions

- Eyeglasses and contact lenses; (please see “Vision Services” in this “Benefits” section);
- Hearing aids under this benefit (please see “Hearing Services” in this “Benefits” section);
- Dental appliances;
- Except as described above, nonrigid supplies such as elastic stockings and wigs;
- Comfort, convenience, or luxury equipment or features;
- Electronic voice-producing machines, except as covered by Medicare; and
- Shoes or arch supports, even if custom made, except footwear described above for diabetes-related

complications and foot disfigurement.

Reconstructive surgery

We cover 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.

■ Mastectomies

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.

Inpatient Services: $250 per admission

Outpatient visits: $10 per visit

Outpatient surgery: $10 per procedure

Note: Prosthetics and orthotics are not covered under this “Reconstructive surgery” section (instead, refer to “Prosthetic and orthotic devices” in this “Benefits” section).

■ Reconstructive surgery exclusions

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

Religious Nonmedical Health Care Institution Services

Certain Services in a Medicare-certified Religious Nonmedical Health Care Institution (RNHCI) are covered under the Kaiser Permanente Senior Advantage Plan. However, religious aspects of care provided in a RNHCI are not covered. If you want to receive care in a RNHCI, please call our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** to learn about the requirements you must satisfy.

Skilled Nursing Facility care

Inside our Service Area, we cover up to **100 days per benefit period** of skilled inpatient Services in a licensed Skilled Nursing Facility when prescribed by a Plan Physician and in accord with Medicare guidelines. The skilled inpatient Services must be Medically Necessary, 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 a Skilled Nursing Facility at a skilled level of care (defined in accord with Medicare guidelines).

A benefit period ends on the date you have:

1. Not been an inpatient in a hospital or a Skilled Nursing Facility for 60 consecutive days; or
2. Not received a skilled level of care in a Skilled Nursing Facility 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 at **no charge:**

- Physician and nursing Services;
- Room and board;
- Medical social Services;
- Blood, blood products, and their administration;
- Medical supplies;
- Services covered under “Physical, occupational, and speech therapy and multidisciplinary Services; and
- Respiratory therapy.

Note:

- Drugs are not covered under this “Skilled Nursing Facility care” section (instead, refer to the “Drugs, supplies, and supplements” section).
- Durable medical equipment is not covered under this “Skilled Nursing Facility care” section (instead, refer to the “Durable medical equipment (DME)” section).
- Imaging, laboratory, and special procedures are not covered under this “Skilled Nursing Facility care” section (instead, refer to the “Imaging, laboratory, and special procedures” section).

Designating a Skilled Nursing Facility

Upon discharge from a Plan Hospital, we will provide Skilled Nursing Facility coverage at the following Skilled Nursing Facilities inside our Service Area (if we have an agreement with the Skilled Nursing Facility to provide you with the care described above):

- The Skilled Nursing Facility where you were residing at the time of your hospital admission;
- A Skilled Nursing Facility that provides post-hospital skilled nursing Services through a continued care retirement community where you were residing at the time of your hospital admission; or
- The Skilled Nursing Facility where your Spouse is residing at the time you are discharged from the hospital.

Note: If you choose to go to a home Skilled Nursing Facility that is not one of our approved facilities, we make no representations about, and assume no liability for, the quality of care provided to you at that facility.

Transplant Services

We cover transplants of organs, tissue, or bone marrow in accord with Medicare guidelines, if 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 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, Medical Group, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor; and

- 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 Medical Group as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. Our criteria for donor Services are available by calling our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

  Inpatient Services: $250 per admission

  Outpatient visits: $10 per visit

Vision Services

We cover the following Services at Plan Medical Offices or Plan optical sales offices when prescribed by a Plan Physician or Plan optometrist:

- **Eye exams.** Refraction exams to determine the need for vision correction and to provide a prescription for eyeglass lenses at **$10 per visit.**

We also cover glaucoma screenings in accord with Medicare guidelines.

Optical Services

Eyeglasses and contact lenses. We provide a **$150 allowance** toward the price of eyeglass lenses, frames, and contact lenses, fitting, and dispensing every 24 months when prescribed by a Plan Physician or Plan optometrist. We will not provide the allowance if we have covered lenses or frames within the previous 24 months. Also, the allowance can only be used at the initial point of sale. If you do not use all of your allowance at the initial point of sale, you cannot use it later.

If you have a change in prescription of at least .50 diopter in one or both eyes within 12 months of the initial point of sale, we will provide an allowance toward the price of a replacement eyeglass lens (or contact lens, fitting, and dispensing). The allowance for these replacement lenses is **$60** for single-vision eyeglass lenses or contact lenses, fitting, and dispensing, and **$90** for multifocal eyeglass lenses.

Special contact lenses. We cover the following special contact lenses at **no charge** when prescribed by a Plan Physician or Plan optometrist:

- We will provide up to two contact lenses per eye every 12 months to treat aniridia (missing iris).
- We will provide up to five aphakic contact replacement lenses per eye under this or any other *DF/EOC* for children from birth through age 9 (aphakia is the absence of the crystalline lens of the eye).
- If contact lenses will provide a significant improvement in your vision not obtainable with eyeglass lenses, we cover either one pair of contact lenses or an initial supply of disposable contact lenses every 24 months. When we cover these special contact lenses, you cannot use the allowance mentioned in "Eyeglasses and contact lenses" for another 24 months. However, if the combination of special contact lenses and eyeglasses will provide a significant improvement in your vision not obtainable with special contact lenses alone, you can use that allowance toward the purchase of the eyeglasses if we have not covered lenses or frames within the previous 24 months. If you have a change in

prescription of at least .50 diopter in one or both eyes, we will cover special contact lens replacements, including fitting and dispensing.

Eyeglasses and contact lenses following cataract surgery. In accord with Medicare guidelines, we provide a **$150 allowance** after each cataract surgery is performed. The allowance is to help you pay for eyeglass lenses, frames, contact lenses, fitting and dispensing, and it can be used only at the initial point of sale. If you do not use all of your allowance at the initial point of sale, you cannot use it later. Also, the allowance for each cataract surgery must be used before a subsequent cataract surgery. There is only one **$150 allowance** following any cataract surgery.

■ Vision Services exclusions

- All Services related to eye surgery or orthokeratologic Services for the purpose of correcting refractive defects such as nearsightedness (myopia), far-sightedness (hyperopia), or astigmatism.
- Industrial frames.
- Lenses and sunglasses without refractive value except for:
  - A balance lens if only one eye needs correction; or
  - Medically Necessary lenses to treat macular degeneration or retinitis pigmentosa.
- Replacement of lost, broken, or damaged lenses or frames.
- Lens adornment, such as engraving, faceting, or jeweling.
- Low-vision devices.
- Nonprescription products, such as eyeglass holders, eyeglass cases, and repair kits.

Exclusions, Limitations, and Reductions

Exclusions

The Services listed below are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under "Section Two, Senior Advantage Plan" of this *DF/EOC*. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits" section.

- **Certain exams and Services.** Physical examinations and other Services:

1. Required for obtaining or maintaining employment or participation in employee programs, or
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 and supplies are Medically Necessary.

- **Chiropractic Services,** except as covered by Medicare. Manual manipulation of the spine, when prescribed by Medical Group or Plan Physician, is provided to Medicare Members under this *DF/EOC.* Please see "Outpatient care" in the "Benefits" section.
- **Conception by artificial means.** All Services (other than artificial insemination described under "Infertility Services") related to conception by artificial means, such as: ovum transplants; gamete intrafallopian transfer (GIFT); donor semen or 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 improve your appearance, except for Services covered under "Reconstructive surgery" and prostheses needed after a mastectomy under "Prosthetic and orthotic devices" in the "Benefits" section.
- **Custodial care.** Custodial care means:

1. Assistance with activities of daily living (example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine), or
2. Care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.

This exclusion does not apply to Services covered under "Hospice care" in the "Benefits" section.

- **Dental care.** Dental care and dental X-rays, such as dental Services following accidental injury to teeth, dental appliances, dental implants, orthodontia, and dental Services resulting from medical treatment (such as surgery on the jawbone and radiation treatment), except for Services covered by Medicare or under "Dental Services for radiation treatment" and "Dental anesthesia" in the "Benefits" section.
- **Experimental or investigational Services.** A Service is experimental or investigational if we, in

consultation with Medical Group, determine that:

- 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); or
- It requires government approval that has not been obtained when the Service is to be provided.

- **Hair loss or growth treatment.** Services for 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 "Hospice care" in the "Benefits" section.
- **Routine foot care Services.** Routine foot care, except for Medically Necessary Services covered by Medicare.
- **Services related to a noncovered Service.** When a Service is not covered, all Services related to the noncovered Service are excluded, except that this exclusion does not apply to Services we would otherwise cover to treat complications of the noncovered Service.
- **Sexual reassignment surgery**
- **Surrogacy.** Services for anyone in connection with a surrogacy arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. Also, Services related to conception by artificial means related to a surrogacy arrangement. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. Please refer to "Surrogacy arrangements" in the "Reductions" section for information about your obligations to us in connection with a surrogacy arrangement, including your obligation to reimburse us for any Services we cover.
- **Travel and lodging expenses.** Travel and lodging expenses, except that in some situations if 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. Our travel and lodging guidelines are available from our Member Service Call Center.

Limitations

- We will do our best to provide or arrange for our Members' health care needs in the event of unusual circumstances that delay or render impractical the provision of Services under this *DF/EOC*, such as 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 disputes. Under these extreme circumstances, if you have an Emergency Medical Condition, go to the nearest hospital as described under "Emergency, Urgent, and Post-stabilization Care" in the "Emergency, Urgent, and Routine Care" section, and we will

provide coverage and reimbursement as described in that section.

Reductions

■ Medicare benefits

As a Senior Advantage Member, you receive all Medicare covered benefits through us (except for hospice care for Members with Medicare Parts A and B and qualifying Clinical Trials, which are covered directly by Medicare) and these benefits are not duplicated.

- **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.** You must pay us Charges for covered Services you receive for an injury or illness that is alleged to be caused by a third party's act or omission, except that you do not have to pay us more than you receive from or on behalf of the third party.

To the extent permitted 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 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 recovery 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:

Northern California Members:

Kaiser Permanente
Special Recovery Unit
COB/TPL
P.O. Box 2073
Oakland, CA 94604-9877

Southern California Members:

Kaiser Permanente
Special Recovery Unit-8553
Parsons East, Second Floor
P.O. Box 7017
Pasadena, CA 91109-9977

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 must not take any action prejudicial to our rights.

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.

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 assert any independent lien rights they may have to recover their General Fees from 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 as Secondary Payer

Auto and liability insurance. When Medicare by law is the secondary payer, federal law authorizes health plans to seek reimbursement from the medical expense provisions of any motor vehicle insurance covering you, and any liability insurance that provides payment for injuries or illness to you. We will reduce your benefits under this *DF/EOC* by all amounts paid or payable under your other health plan or insurance policy. You must complete and submit to us all consents, releases, assignments, and other documents necessary for us to obtain or assure such payment. If you fail to do so, then we may, at our discretion, require you to pay for the Services.

Coordination of benefits (COB). In certain cases, this *DF/EOC* is subject to coordination of benefits. COB applies when you have health benefits coverage through more than one health care plan and one of them is group coverage that is subject to Medicare secondary payer law. If federal law requires that a group's coverage be primary and Medicare coverage be secondary, we or the other health care plan will coordinate benefits with the plan whose group coverage is primary by law. We will ask if you have other coverage. If you have other health care plan coverage, you must help us obtain payment from them by providing the information we request. The following are situations when Medicare is secondary for the purposes of COB:

- If you are age 65 or older and have group health care coverage through an employer with 20 or more employees, either through your or your Spouse's current employment (this applies to most employers with 20 or more employees);
- If you are under age 65 and entitled to Medicare due to disability and have coverage under a large employer group health plan (100 or more employees), either through your own employment or the employment of a family Member; or

- If you become eligible for, or entitled to, Medicare based on end-stage renal disease (ESRD) and are covered by an employer group health plan, you will be subject to a 30-month benefit coordination period, during which time Medicare is secondary payer, if: (1) ESRD is the sole basis for your Medicare eligibility or entitlement, (2) you also become eligible for or entitled to Medicare based on age or disability during the first 30 months of your ESRD-based eligibility or entitlement, or (3) you are entitled to Medicare based on age or disability and are subject to Medicare secondary payer provisions (refer to the first two bullets above).

- **Surrogacy arrangements.** You must pay us the Charges for covered Services you receive related to conception, pregnancy, or delivery in connection with a surrogacy arrangement ("Surrogacy Health Services"). Your obligation to pay us for Surrogacy Health Services is limited to the compensation you are entitled to receive under the surrogacy arrangement. A surrogacy arrangement is one in which you agree to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or your chosen 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. 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 the names and addresses of the other parties to the arrangement, and a copy of any contracts or other documents explaining the arrangement, to the following address:

Northern and Southern California Members:

Kaiser Permanente
Special Recovery Unit
Parsons East, Second Floor
P.O. Box 7017
Pasadena, CA 91109-9977

Attention: Third-Party Liability Supervisor

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 must not take any action prejudicial to our rights.

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 a "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:

1. From any source providing a Financial Benefit or from whom a Financial Benefit is due; or

2. 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.

Requests for Payment or Services

Requests for payment

Non-Plan Emergency Care, Out-of-Area Urgent Care, Post-stabilization Care, and Out-of-Area Dialysis Care. If you receive Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care, from a non-Plan Provider, as described in the "Emergency, Urgent, and Routine Care" section, or Out-of-Area dialysis care from a non-Plan Provider, as described in the "Benefits" section, ask the non-Plan Provider to submit a claim to us within 60 days or as soon as possible, but no later than 15 months after receiving care (or up to 27 months according to Medicare rules, in some cases). If the provider refuses and bills you, send us the unpaid bill with a claim form. To file a claim, this is what you need to do:

- As soon as possible, get our claim form by calling our Member Service Call Center toll free at **1-800-443-0815 or 1-800-390-3510 (TTY 1-800-777-1370), 7 a.m. to 7 p.m., seven days a week.** Also, one of our representatives will be happy to assist you if you need help completing our claim form.
- If you have paid for Services, you must send us our completed claim form for reimbursement. Please attach any bills from the non-Plan Provider and receipts.
- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled.
- The completed claim form must be mailed to the following address as soon as possible, but no later than 15 months after receiving care (or up to 27 months according to Medicare rules, in some cases). Please do not send any bills or claims to Medicare. Any additional information we request should also be mailed to the following addresses:

Northern California Members:

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

Southern California Members:

Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 7102
Pasadena, CA 91109-9880

We will notify you of our decision within 60 days after we receive your claim. If we totally or partially deny your claim, we will notify you in writing of the reasons for denial and of your right to seek reconsideration. If you have not received a determination on your claim within 60 days after we receive your claim, you may assume the determination is negative and you may use the Medicare appeals procedure described in the "Dispute Resolution" section.

Other Services

To request payment for Services that you believe should be covered, other than the Services described above, you or your non-Plan Provider must submit a written request to your local Member Services Department at a Plan Facility. Please

attach any bills and receipts if you have paid any bills. Please be aware that we may not pay for Services provided by non-Plan Providers who have been sanctioned or debarred by Medicare, or who have opted out of Medicare.

We will respond to your claim within 60 days. If we deny your claim, we will tell you the specific reasons for the denial. If you have not received a notice about our determination on your claim within 60 days after we receive it, you may assume the decision is negative and you may request an appeal. Likewise, if you disagree with our decision, you may appeal our decision as described in the "Dispute Resolution" section.

Requests for Services

■ Requests for Services that you have not yet received

Standard decision. You may request that we provide Services that you have not yet received (except for hospice care for Members with Medicare Parts A and B), but that you believe you are entitled to receive through Kaiser Permanente. These requests should be submitted in writing to your local Member Services Department at a Plan Facility. We will respond to your request within 14 days. If we deny your request, we will send you a notice that explains the reason for the denial and provides information about your appeal rights as described in the "Dispute Resolution" section.

Expedited decision. You may ask that we make an expedited decision on your request. Expedited requests may be made orally or in writing. We will make an expedited decision within 72 hours if we find, or if your physician states, that your health or ability to regain maximum function could be seriously harmed by waiting 14 days for a standard decision. We may extend our decision for up to 14 days if it is in your interest, or if you request an extension. For example, our decision may take longer if we have to wait for medical information from a non-Plan Provider. If we must extend the time frame, we will provide written notice. If you disagree with our decision to extend the time frame, you may file a grievance or an expedited grievance as described in the "Dispute Resolution" section.

You or your physician may request an expedited decision in one of the following ways:

- Call toll free **1-888-987-7247.**
- Send your written request to:

  Kaiser Foundation Health Plan, Inc.
  Advocacy Program
  P.O. Box 12983
  Oakland, CA 94604-2983
  Attention: Medicare Expedited Review
- Fax your written request to **1-888-987-2252.**
- Deliver your request in person to your local Member Services Department at a Plan Facility.

Specifically state that you want an expedited decision, 72-hour decision, or that you believe that your health could be seriously harmed by waiting 14 days for a decision. If we deny your request for an expedited decision, we will give you prompt oral notice and provide written notice within 72 hours. The notice will include information about your grievance or expedited grievance rights as described in the "Dispute Resolution" section. Also, we will automatically transfer your request for a standard decision review and make a decision within 14 days from the date of the request.

Dispute Resolution

We are committed to providing you with quality care and with a timely response to your concerns if an issue arises. Our Member Service representatives are available to discuss your concerns at most Plan Facilities or you can call our Member Service Call Center toll free at **1-800-443-0815 (TTY 1-800-777-1370) 7 a.m. to 7 p.m., seven days a week.** The following procedures for resolving disputes are discussed in detail below:

1. **Standard Medicare appeal procedure.** To appeal denied claims for payment or denied requests for Services when an expedited Medicare appeal is not required.
2. **Expedited Medicare appeal procedure.** To appeal discontinuation of Services, or denied requests for Services when your health or ability to function could be seriously harmed by waiting 30 days for a standard Medicare appeal.
3. **Immediate Quality Improvement Organization (QIO) review.** To appeal denial of continued coverage of a stay in a hospital when we have determined that hospitalization is no longer Medically Necessary.
4. **Grievance procedure.** To report any quality of care concerns you have and to seek resolution of an issue that is not subject to a Medicare appeals procedure.
5. **Quality Improvement Organization complaint procedure.** To report concerns about the quality of care you receive, you can also file a complaint with your local Quality Improvement Organization.
6. **Binding arbitration.** To resolve all other claims arising from your Membership, unless otherwise indicated below.

■ Special note about hospice care

For Members entitled to Medicare Parts A and B, Medicare covers hospice care directly and it is not covered under this *DF/EOC*. Therefore, any disputes related to the coverage of hospice care for Members entitled to Medicare Parts A and B must be resolved directly with Medicare and not through any dispute resolution procedure discussed in this section.

Standard Medicare appeal procedure

This procedure applies to denied requests for Services and denied claims for payment of Services received from non-Plan Providers, including those related to Emergency Care, Out-of-Area Urgent Care, Post-stabilization Care, and Out-of-Area dialysis care (it does not apply to hospice care for Members entitled to Medicare Parts A and B).
For claims, we will process your reconsideration request within 60 days. For denied requests for Services that you believe are covered under this *DF/EOC*, we will process your reconsideration request within 30 days from receipt of the reconsideration request. If it is in your best interest, or if you request, we may extend our decision for an additional 14 days beyond the 30-day period. If we must extend the time frame, we will provide written notice. If you disagree with our decision to extend the timeframe you may file a grievance

as described in the "Grievances" section below. **We will use this procedure to reconsider all claims and requests unless the expedited (72-hour) Medicare appeal procedure applies.**

If we deny your initial claim for payment or request for Services, we will tell you the specific reasons for the denial in a written denial notice. If you disagree with our decision, you have the right to request a reconsideration of our decision. Your reconsideration request must be filed in writing with us at the address shown on your denial notice, or with an office of the Social Security Administration, or if you are a qualified Railroad Annuitant, with the Railroad Retirement Board office. Even though you may file your reconsideration request with the office of the Social Security Administration or with the Railroad Retirement Board office, that office will transfer your reconsideration request to us for processing.

You must submit your reconsideration request within 60 days from the date on the denial notice, unless you show good cause for a delay past 60 days. You have the right to submit any new information to support your reconsideration request in person or in writing.

If we do not rule fully in your favor, we will forward your reconsideration request to the CMS contractor, The Center for Health Dispute Resolution (The Center), for a decision. The Center will then make its own reconsideration decision and advise you of its decision, the reason for its decision, and your rights to a hearing before an administrative law judge.

If our standard reconsideration decision is fully in your favor for the Services you requested, we will authorize or provide the Service to you as quickly as your health condition requires, but no later than 30 days from receipt of your reconsideration request. If our decision is fully in your favor for a request for payment, we will pay for the Services no later than 60 days from receipt of your reconsideration request.

If The Center's decision is in your favor for a request for Service, we will do one of the following:

- Authorize those Services as quickly as your health condition requires, but no later than 72 hours from the date we receive notice of The Center's decision; or
- Provide those Services as quickly as your health condition requires, but no later than 14 days from the date we receive notice of The Center's decision.

If The Center's decision is in your favor for a request for payment, we will pay for the Service within 30 days from receipt of The Center's decision.

Expedited Medicare appeal procedure

This procedure applies to denied requests for Services that you believe we should provide, arrange, or continue (does not apply to hospice care for Members entitled to Medicare Parts A and B). This procedure does not apply to denied claims for payment. You may ask that we make an expedited decision on your reconsideration request. We will make an expedited decision within 72 hours if we find, or if your physician states, that your health or ability to regain maximum function could be seriously harmed by waiting 30 days for the standard Medicare appeal procedure

decision. If it is in your best interest, we may extend the time frame to make our decision for an additional 14 days beyond the 72-hour period. For example, you may need time to provide us with additional information, or we may need to have additional diagnostic tests completed. Also, our decision may take longer than 72 hours if we have to wait for medical information from a non-Plan Provider.

You must submit your reconsideration request within 60 days of the date on the denial notice. You or your physician may request an expedited Medicare reconsideration request by calling toll free **1-888-987-7247,** or by writing to:

Kaiser Foundation Health Plan, Inc.
Advocacy Program
P.O. Box 12983
Oakland, CA 94604-2983

Attention: Medicare Expedited Review

You may also fax your request to **1-888-987-2252,** or deliver your request in person to your local Member Services Department at a Plan Facility. Specifically state that you want an expedited reconsideration decision, 72-hour reconsideration decision, or that you believe that your health could be seriously harmed by waiting 30 days for a decision.

If we deny your request for an expedited Medicare reconsideration request, we will automatically review your request under the standard Medicare appeal procedure. You do not need to submit a separate reconsideration request. If you disagree with our decision not to expedite your reconsideration request, you may file a grievance as described in the "Grievances" section below. If our decision under the standard or expedited Medicare appeal procedure is not fully in your favor, we will automatically forward your request for reconsideration to the CMS contractor, The Center for Health Dispute Resolution (The Center), for an independent review. The Center will send you a letter with their decision within 72 hours of receipt of your case.

If our expedited decision is fully in your favor for the Services you requested, we will authorize or provide those Services to you as quickly as your health condition requires, but no later than 72 hours from receipt of your reconsideration request. If The Center's decision is in your favor for the Services you requested, we will authorize or provide those Services as quickly as your health condition requires, but no later than 72 hours from the date we receive notice of The Center's decision.

■ Support for your request

You are not required to submit additional information to support your request for Services or payment for Services already received. We are responsible for gathering all necessary information, however, it may be helpful to you to include additional information to clarify or support your position. For example, you may want to include in your reconsideration request, information such as medical records or physician opinions in support of your reconsideration request. We will obtain medical records from Plan Providers on your behalf. If you have received Services from a non-Plan Provider, you will need to contact the non-Plan Provider to obtain your medical records. You may need to send or fax a written request. Ask your physician to send or fax the records directly to us, if possible. We will provide an opportunity for you

to provide additional information in person or in writing.

You may submit any new evidence to support your reconsideration request of denied requests for Services by mail, fax, or phone (or in person) at the numbers or addresses listed above for expedited Medicare appeals and standard Medicare appeals.

If you decide to appeal or request reconsideration and want help, you may have a doctor, friend, lawyer, or someone else help you. There are several groups that can help you. The following numbers are toll free:

- Health Insurance Counseling and Advocacy Program **1-800-434-0222 (TTY 1-800-722-3140)**
- Medicare Rights Center

  1-888-HMO-9050
- State Ombudsman

  (for Skilled Nursing Facility issues)

  1-800-231-4024
- Area Agency on Aging **1-800-510-2020** (varies by county, check your telephone book) or call Eldercare Locator at **1-800-677-1116**

For information about who may file an appeal, please refer to "Who may file" below.

If you disagree with The Center's decision

If you disagree with The Center's decision about your standard or expedited reconsideration request, you may request a hearing before an administrative law judge by filing a written request at a Social Security office (or at a Railroad Retirement Board office if a Railroad Annuitant) or by writing to one of the following locations:

The Center for Health
Dispute Resolution
1 Fishers Rd., Second Floor
Pittsford, NY 14534-9597

Northern California Members:

Kaiser Foundation Health Plan, Inc.
Member Relations
P.O. Box 12983
Oakland, CA 94604

Southern California Members:

Kaiser Foundation Health Plan, Inc.
Member Services
393 E. Walnut Street
Pasadena, CA 91188

This request must be filed within 60 days after the date of notice of The Center's adverse decision. This 60-day notice period may be extended for good cause by the administrative law judge. A hearing can be held only if the amount in controversy is $100 or more, as determined by the administrative law judge. An adverse decision by the administrative law judge may be reviewed by the Departmental Appeals Board (DAB) of the Department of Health and Human Services, either by its own action or as the result of a request from you or from us. If the amount involved is $1,000 or more, either you or we may request that a decision made by the DAB be reviewed by a federal district court. The party requesting judicial review must notify the other parties involved. An initial, revised, or appeal determination made by us, The Center, an administrative law judge, or the DAB may be reopened (a) within 12 months, (b) within four years for just cause, or (c) at any time for clerical correction or in cases of fraud.

Immediate Quality Improvement Organization (QIO) review

You may request an immediate Quality Improvement Organization (QIO) review if you believe you are being asked to leave the hospital too soon and we deny coverage of your continued stay in the hospital because hospitalization is no longer Medically Necessary. A QIO is a group of doctors paid by the federal government to review the medical necessity, appropriateness, and quality of hospital treatment furnished to you. When we inform you that you are being discharged, we will provide you a written "Notice of Discharge and Medicare Appeal Rights" that describes in detail the procedures available to you to request a QIO review.

When you are admitted to any hospital, you will be provided a document entitled "An Important Message to Medicare Beneficiaries." The document describes your rights while you are a hospital patient. Those rights include:

1. The right to receive all hospital care that is necessary for the proper diagnosis and treatment of your illness or injury and the right to have your discharge date determined solely by your medical need and not by any method of payment;
2. The right to be fully informed about decisions affecting the coverage and payment of your hospital stay and for any post-hospital Services; and
3. The right to request a review by a QIO if we determine that your hospital stay is no longer Medically Necessary and you disagree.

■ Requesting QIO review

When you receive the "Notice of Discharge and Medicare Appeal Rights," if you believe that you are being asked to leave the hospital too soon, you may request an immediate QIO review by phone or in writing. If you request a QIO review by noon of the first business day after you receive the "Notice of Discharge and Medicare Appeal Rights," you will not be financially responsible for the cost of your hospitalization until the QIO makes a decision. By requesting QIO review, you may not use the standard Medicare appeal procedure or expedited Medicare appeal procedure described above. The QIO will respond to your request for review of the "Notice of Discharge and Medicare Appeal Rights" by phone or in writing. The QIO will ask you your views about your case before making a decision.

If the QIO agrees with the "Notice of Discharge and Medicare Appeal Rights," you will be financially responsible for all costs of hospitalization beginning at noon of the day after you receive the QIO decision. If you do not agree with the QIO decision, you may request that the QIO immediately reconsider your case. The QIO may take up to three business days from receipt of your appeal to make a decision. The QIO will inform you in writing of the reconsideration decision. If the QIO continues to agree with the "Notice of Discharge and Medicare Appeal Rights," you will be financially responsible for the cost of your continued hospitalization, beginning at noon of the day after you received the first QIO decision. If, upon reconsideration, the QIO disagrees with the "Notice of Discharge and Medicare Appeal Rights," you will not be financially responsible for the cost of any additional hospital days approved by the QIO.

Note: If you do not request a QIO review, you will be financially responsible for the cost of your hospitalization beginning on the first day after receipt of the "Notice of Discharge and Medicare Appeal Rights." You may use the standard Medicare appeal procedure or expedited Medicare appeal procedure described above if you do not request a QIO review. However, you may be financially responsible for the cost of your hospitalization, beginning on the first day after receipt of the "Notice of Discharge and Medicare Appeal Rights," if the appeal decision is not in your favor.

Grievances

You can file a grievance for any issue that is not subject to a Medicare appeals procedure described above. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with the Services you received. Grievances may be submitted orally or in writing and they must be submitted to a Member Service representative or through our Web site at *www.members.kp.org*.

We will send you a confirming letter within five days of our receipt of your grievance. We will send you our written decision within 30 days. If we deny your grievance in whole or in part, our written decision will fully explain why we denied it and additional dispute resolution options.

■ Expedited grievances

You may make an oral or written request that we expedite your grievance if we:

- Deny your request to expedite a decision related to a Service that you have not yet received under "Expedited decision" in the "Request for Payment or Services" section.
- Deny your request to expedite your Medicare appeal described under "Expedited Medicare appeals procedure" in this section.
- Decide to extend the time we need to make a standard or an expedited decision under "Standard decision" or "Expedited decision" in the "Request for Payment or Services" section and under "Standard Medicare Appeals Procedure" or "Expedited Medicare appeals procedure" in this section.

If you request an expedited grievance, we will respond to your request within 24 hours.

Quality Improvement Organization complaint procedure

If you are concerned about the quality of care you have received, you may also file a complaint with the local Quality Improvement Organization, by writing to California Medical Review, Inc., One Sansome St., Suite 600, San Francisco, CA 94104-4448, fax number (415) 677-2185, or by calling toll free at **1-800-841-1602.** Quality Improvement Organizations are groups of doctors and health professionals that monitor the quality of care provided to Medicare beneficiaries. The Quality Improvement Organization review process is designed to help stop any improper practices.

Who may file

The following persons may file a grievance, appeal, or reconsideration request:

- You may file for yourself.

- You may appoint someone as your authorized representative by completing our authorization form. Authorization forms are available from your local Member Services Department at a Plan Facility or by calling our Member Service Call Center. Your completed authorization form must accompany the request.
- You may file for your Dependent children, except that they must appoint you as their authorized representative if they have the legal right to control release of information that is relevant to the request.
- You may file for your ward if you are a court-appointed guardian.
- You may file for your conservatee if you are a court-appointed conservator.
- You may file for your principal if you are an agent under a health care proxy, to the extent provided under state law.
- Your physician may request an expedited appeal as described under "Expedited (72-hour) Medicare appeal procedure" above.
- A non-Plan Provider may file a standard reconsideration request of a denied claim if he or she completes a waiver of liability statement that says he or she will not bill you regardless of the outcome of the reconsideration request.

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 *DF/EOC*. 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:

1. The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *DF/EOC* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. (Health Plan), including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, Services, irrespective of the legal theories upon which the claim is asserted;
2. 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;
3. The claim is *not* within the jurisdiction of the Small Claims Court; and
4. The claim is not subject to a Medicare appeals procedure.

As referred to in this "Binding arbitration" section,

1. "Member Parties" include:
   a. A Member; or
   b. A Member's heir or personal representative; or

   c. Any person claiming that a duty to him or her arises from a Member's relationship to one or more Kaiser Permanente Parties.

2. "Kaiser Permanente Parties" include:
   a. Kaiser Foundation Health Plan, Inc. (Health Plan);
   b. Kaiser Foundation Hospitals (KFH);
   c. The Permanente Medical Group, Inc. (TPMG);
   d. Southern California Permanente Medical Group (SCPMG);
   e. The Permanente Federation, LLC;
   f. The Permanente Company, LLC;
   g. Any KFH, TPMG, or SCPMG physician;
   h. Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties; or
   i. Any employee or agent of any of the foregoing.
3. "Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts a claim as described above.
4. "Respondent" refers to a Member Party or a Kaiser Permanente Party against whom a claim is asserted.

Arbitration Oversight Board and Independent Administrator. In 1997, Health Plan assembled a Blue Ribbon Panel to evaluate the arbitration system and recommend improvements. The Panel's recommendations included the establishment of an Independent Administrator to oversee the arbitration process and an Advisory Committee with broad representation to assist in the independent administration. The Independent Administrator and the Advisory Committee established Rules of Procedure applicable to Health Plan's arbitration system. In 2002, the Advisory Committee was replaced by an Arbitration Oversight Board.

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 all claims against Respondents that are based on the same incident, transaction, or related circumstances in the Demand for Arbitration.

Serving Demand for Arbitration. Health Plan, KFH, TPMG, SCPMG, 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:

Northern California Members:

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

Southern California Members:

Kaiser Foundation Health Plan, Inc.
Legal Department
393 E. Walnut Street
Pasadena, CA 91188

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 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 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 the Kaiser Permanente Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

Number of Arbitrators. The number of Arbitrators may affect the Claimant's responsibility for paying the Neutral Arbitrator's fees and expenses.

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 a 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 Arbitrator fees and expenses. Health Plan will pay the fees and expenses of the Neutral Arbitrator under certain conditions as set forth in the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* (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.

Rules of Procedure. Arbitrations shall be conducted according to Rules of Procedure developed by the Independent Administrator in consultation with

Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from the Member Service Call Center by calling toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

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 Respondents served by the applicable statute of limitations; or
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 (i) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (ii) 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 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 noneconomic 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 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 section.

Termination of Membership

The University 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, 2004, your last minute of coverage was at 11:59 p.m. on December 31, 2003). 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 *DF/EOC* after your Membership terminates, except:

- As provided under "Coverage for disabling condition if your Group's *Agreement* terminates" in the "Continuation of Membership" section and "Payments after termination" in this "Termination of Membership" section; and
- If you are receiving covered Services as an acute care hospital inpatient on the termination date, we will continue to cover those hospital Services (but not physician Services or any other Services) until you are discharged.

Note: Until your Membership terminates, you remain a Senior Advantage Member and must continue to receive your medical care from us, except as described in the "Emergency, Urgent, and Routine Care" section about Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care and in the "Benefits" section about Out-of-Area dialysis care.

Disenrolling from Senior Advantage

You may terminate (disenroll from) your Senior Advantage Membership at any time and return to the original (non-Kaiser Permanente) Medicare fee-for-service program. However, before you request disenrollment, you should check with your Group's Benefits Administrator to determine if you are able to continue your Group Membership.

If you request disenrollment during your Group's open enrollment, your disenrollment effective date is determined by the date your written request is received by us and the date your Group coverage ends. The effective date will not be earlier than the first day of the month following receipt of your written request, and no later than three months after receipt of your request.

If you request disenrollment at a time other than your Group's open enrollment, your disenrollment effective date will be the first day of the month following our receipt of your disenrollment request.

You may disenroll by sending written notice to the address below. Also, you may disenroll at any Social Security office or Railroad Retirement Board office (if you are a Railroad Annuitant) by completing a written request for disenrollment. In addition, you may also call CMS toll free at **1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048).** However, although optional, we request that if you disenroll at a Social Security office or Railroad

Retirement Board office, you also notify us.

Northern California Members:

Kaiser Permanente Senior Advantage
California Service Center
P.O. Box 232400
San Diego, CA 92193-2400
1-800-443-0815
(1-800-777-1370 TTY),
7 a.m. to 7 p.m.,
seven days a week.

Southern California Members:

Kaiser Permanente Senior Advantage
California Service Center
P.O. Box 232407
San Diego, CA 92193-2407
1-800-443-0815
(1-800-777-1370 TTY),
7 a.m. to 7 p.m.,
seven days a week.

Note: If you enroll in another Medicare+Choice Plan, CMS will automatically terminate your Senior Advantage Membership when your Membership in the other organization becomes effective. In this case, do not send us a disenrollment request. If you disenroll and have Part B only, you will have to purchase Medicare Part A from the Social Security Administration to re-enroll in Senior Advantage in the future or to enroll in another Medicare+Choice Plan.

Termination of *Group 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 due to loss of eligibility

If you meet the eligibility requirements described in the "Who is eligible" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your Membership will end at 11:59 p.m. on the last day of that month, unless your Group has an agreement with us to terminate at a time other than the last day of the month. Please check with your Group Benefits Administrator to confirm your termination date.

Also, we will terminate your Senior Advantage Membership on the last day of the month if you:

- Are temporarily absent from our Service Area for more than six months;
- Permanently move from our Service Area; or
- Are no longer entitled to Medicare Parts A or B. Your Senior Advantage Membership termination will be effective the first day of the month following the month when Medicare Parts A or B end. **Note:** If you were enrolled in Senior Advantage on December 31, 1998, and you did not have Medicare Part A, you will not be terminated simply because you continue to not be entitled to Medicare Part A through Social Security.

Note: If you lose eligibility for Senior Advantage due to these circumstances, you may be eligible to transfer your Membership to another Kaiser Permanente Plan offered by your Group. Please contact your Group's Benefits Administrator for information or refer to

the "Continuation of Membership" section for details.

The University of California establishes its own health plan criteria for when group coverage for employees and Annuitants ceases, based on the University of California Group Insurance Regulations. Portions of these regulations are summarized below.

1. **Subscriber and Dependents.** Group coverage ceases for a Subscriber and all enrolled Dependents when the Subscriber ceases to be eligible for group coverage.
2. **Dependents only.** When your family Members no longer meet the eligibility requirements for coverage as Dependents, their right to receive benefits ends on the last day of the month in which the family member is no longer eligible.

   Spouse: In the event of divorce, legal separation, or annulment, a Spouse loses eligibility as a Dependent at the end of the month in which the action is final.

   Adult Dependent relative or same-sex domestic partner: When you no longer meet the University of California's eligibility requirements.

   Child: Your child loses eligibility as a Dependent:

   - At the end of the month in which the child marries, regardless of age; or
   - At the end of the month in which the child reaches the group age limit(s) for continuing group coverage or ceases to meet any other eligibility requirements for dependency status specified in your *Group Agreement.*

Exception: We will continue coverage for a Dependent who is incapable of self-support due to a physical or mental handicap as specified in the "Who is eligible" section of this booklet. You must furnish us with proof of his or her incapacity and dependency within 31 days after we request it.

If your Membership under this *DF/EOC* ends, you may be eligible to maintain Health Plan Membership without a break in coverage under this *DF/EOC* (group coverage) or you may be eligible to convert to a nongroup Plan (Individual Plan). Please see the "Continuation of Membership" section for details.

You must notify the University immediately of any changes that may affect eligibility of any enrolled family member.

Termination of contract with CMS

If our contract with CMS to offer Senior Advantage terminates, your Membership will terminate on the same date. We will send you advance written notice and advise you of your health care options. Also, you may be eligible to transfer your Membership to another Kaiser Permanente Plan offered by your Group.

Termination for cause

If you commit one of the following acts, we may terminate your Membership immediately by sending written notice to the Subscriber; termination will be effective on the date we send the notice:

- Your behavior threatens the safety of Plan personnel, or of any person or property at a Plan Facility. Any such termination requires CMS approval.

- You commit theft from Health Plan, from a Plan Provider, or at a Plan Facility.
- You knowingly commit fraud in connection with Membership, Health Plan, or a Plan Provider. Some examples of fraud include:
  - misrepresenting eligibility information about you or a Dependent;
  - presenting an invalid prescription or physician order;
  - misusing a Health Plan ID card (or letting someone else use it);
  - giving us incorrect or incomplete material information; and
  - 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 until you have completed a Member Orientation and have signed a statement promising future compliance. We may report fraud and other illegal acts to the authorities for prosecution.

Termination for nonpayment

You are entitled to health care coverage under this *DF/EOC* only for the period for which we receive the appropriate Dues from your Group. If your Group fails to pay us the appropriate Dues for your Family Unit, we may terminate the Memberships of everyone in your Family Unit.

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 by law. If we discontinue offering a particular product in a market, we will terminate just the particular product upon 90 days prior written notice to you. If we discontinue offering all products to groups in a small or large group market, as applicable, we may terminate the *Group Agreement* upon 180 days prior written notice to you.

Certificates of Creditable Coverage

The Health Insurance Portability and Accountability Act requires employers or health plans to issue "Certificates of Creditable Coverage" to terminated Members. The certificate documents health care Membership and is used to prove prior creditable coverage when a terminated Member seeks new coverage. When your Membership terminates, we will mail the certificate to the Subscriber. If you have any questions, please call our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week).**

Payments after termination

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

- Refund any amounts we owe your Group for Dues paid for the period after the termination date; and
- Pay you any amounts we have determined that we owe you for claims during your Membership in accord with "Non-Plan Emergency Care, Out-of-Area Urgent Care, Post-stabilization Care, and Out-of-Area Dialysis Care" in the "Requests for Payment or Services" section. Any amounts you owe us will be

deducted from any payment we make to you.

Review of Membership termination

If you believe that we terminated your Membership because of your ill health or your need for care, you may file a grievance as described in the "Dispute Resolution" section.

Continuation of Membership

If your Membership under this *DF/EOC* ends, you may be eligible to maintain Health Plan Membership without a break in coverage under this *DF/EOC* (group coverage) or you may be eligible to convert to an Individual (nongroup) Plan.

Continuation of Group Coverage under COBRA

You may be able to continue your coverage under this *DF/EOC* for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. COBRA applies to employees (and their covered family Dependents) of most employers with 20 or more employees. Members are not ineligible for COBRA continuation coverage solely because they live in the service area of a Region outside California.

You must submit a COBRA Election Form to your Group within the COBRA election period. Please ask your Group's Benefits Administrator for the details about COBRA continuation coverage, such as how to elect coverage and how much you must pay.

As described in "Conversion of Group Membership to an Individual Plan" in this 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.

Converting Group Coverage under federal or state law

■ Optional continuation of coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, enrolled persons who would lose coverage under the Kaiser Permanente Senior Advantage medical Plan due to certain "qualifying events" are entitled to elect, without having to submit evidence of good health, continued coverage at their own expense. Continued coverage shall be the same as for active eligible employees and their eligible Dependents under the University Group Plan. If coverage is modified for active eligible employees and their Dependents, it shall be modified in the same manner for persons with continued coverage (qualified beneficiaries) and an appropriate adjustment in premiums may be made.

■ Right to continue benefits

A right under this part is subject to the rest of these provisions:

You have the right to continue benefits under the Plan for yourself and any enrolled Dependents if your coverage would have ended because of the following qualifying events:

1. Because your employment ended for a reason other than gross misconduct; or
2. Because your work hours were reduced (including approved leave without pay or layoff).

Each of your eligible Dependents has the right to continue benefits under the Plan under the following circumstances:

In the case of your eligible Dependent Spouse, your Spouse may continue coverage for himself or herself and any enrolled Dependent children if your Spouse's coverage would have ended because of any of the following qualifying events:

1. Because your employment ended for a reason other than gross misconduct; or
2. Because your work hours were reduced (including approved leave without pay or layoff); or
3. At your death; or
4. Because you became entitled to Medicare benefits; or
5. When your Spouse ceased to be an eligible Dependent as a result of a divorce, legal separation, or annulment.

If coverage ends under (5) immediately above, please see **"Notice"** below.

In the case of your eligible Dependent child, your child may continue coverage for himself or herself if your child's coverage would have ended because of any of the following qualifying events:

1. Because your employment ended for a reason other than gross misconduct; or
2. Because your work hours were reduced (including approved leave without pay or layoff); or
3. At your death; or
4. Because you became entitled to Medicare benefits; or
5. Because of your divorce, legal separation, or annulment; or
6. When your eligible Dependent child ceased to be an eligible Dependent under the rules of the Plan.

If coverage for an eligible Dependent ends due to an event shown in (5) or (6) immediately above, please see **"Notice"** below.

For qualifying event (1) or (2), if you become entitled to Medicare, due to age, within 18 months before the qualifying event, your eligible Dependent Spouse or your eligible Dependent child may continue COBRA coverage for up to 36 months counted from the date you became entitled to Medicare.

If a second qualifying event occurs to a qualified beneficiary who already has continuation coverage because your employment has ended or work hours were reduced, the qualified beneficiary's coverage may be continued up to a maximum of 36 months from the date of the first qualifying event.

Notice: If your coverage for an eligible Dependent ends due to your divorce, legal separation, or annulment, or if your eligible Dependent ceases to be an eligible Dependent under the rules of the Plan, you or your eligible Dependent must give written notice of the event to the employer at the University of California Customer Service Center within sixty (60) days of the event or eligibility to elect continuation coverage will be lost.

■ Continuation

Once aware of a qualifying event, the employer will give a written election notice of the right to continue the coverage to you (or to the qualified

beneficiary in the event of your death). Such notice will state the amount of the premium required for the continued coverage. If a person wants to continue the coverage, the election notice must be completed and returned to the following address within sixty (60) days of the later of:

1. The date of the qualifying event; or
2. The date the qualified beneficiary received notice informing the person of the right to continue.

   Kaiser Foundation Health Plan, Inc.
   P.O. Box 23127
   San Diego, CA 92193-3127
   Attention: COBRA

   1-888-236-4490

Benefits of the continuation Plan are identical to this group medical Plan, and the cost is explained on page 171 under "Cost of continuation coverage."

The continued coverage period runs concurrently with any other University continuation provision (such as during leave without pay) except continuation under the Family and Medical Leave Act (FMLA). Coverage will be continued from the date it would have ended until the first of these events occurs:

1. With respect to yourself and any qualified beneficiaries, the day 18 months from the earlier of the date:
   a. Your employment ends for a reason other than gross misconduct, or
   b. Your work hours are reduced. But coverage may continue for all qualified beneficiaries for up to 11 additional months while the qualified beneficiary is determined to be disabled under Title II or XVI of the United States Social Security Act if:
      i. The disability was determined to exist at the time, or during the first sixty (60) days, of the 18 months of COBRA coverage; and
      ii. The person gives Health Plan written notice of the disability within sixty (60) days after the determination of disability is made and within 18 months after the date employment ended or work hours were reduced.

Kaiser Permanente must be notified if there is a final determination under the United States Social Security Act that the person is no longer disabled. The notice must be provided within thirty (30) days after the final determination. The coverage will end on the first of the month that starts more than thirty (30) days after the determination.

2. With respect to your qualified beneficiaries (other than yourself), the day 36 months from the earliest of the date:
   a. Of your death; or
   b. Of your entitlement to Medicare benefits; or
   c. Of your divorce, annulment, or legal separation from your Spouse; or
   d. Your Dependent child ceases to be an eligible Dependent under the rules of the Plan.

The 36 months will be counted from the date of the earliest qualifying event.

3. With respect to any qualified beneficiary:

a. If the person fails to make any premium payment required for the continued coverage, the end of the period for which the person has made required payments.

b. The day the person becomes covered (after the day the person made the election for continuation of coverage) under any other group health plan, on an insured or uninsured basis. This item 3(b) by itself will not prevent coverage from being continued until the end of any period for which pre-existing conditions are excluded or benefits for them are limited under the other health plan.

c. The day the person becomes entitled to Medicare benefits.

d. The day the employer no longer provides group health coverage to any of its employees.

California continuation coverage

Employees entitled to COBRA continuation coverage due to employment termination on or after January 1, 1996, are entitled to extend medical coverage for themselves and their Spouses after their initial 18-month COBRA period ends, provided the employee was at least age 60 on the date employment ended, had worked for the University for at least five continuous years immediately prior to termination, and was eligible for and elected COBRA continuation medical plan coverage in connection with the termination of employment. The former Spouse of the above former employee is entitled to California continuation coverage, provided the former Spouse continued coverage under COBRA as a qualified beneficiary. This continuation does not apply to children of a former employee. The continuation will end on the earlier of:

1. The date the individual turns 65;
2. The date the University no longer maintains the group plan, including any replacement plan;
3. The date the individual is covered by a group medical plan not maintained by the University;
4. The date the individual becomes entitled to Medicare; or
5. With respect to the Spouse or former Spouse only, the date five years from the date COBRA ends for the Spouse or former Spouse.

If the employee's coverage terminates, the Spouse may continue coverage until one of the terminating events applies to the Spouse. Kaiser Permanente will notify eligible COBRA-qualified beneficiaries before the end of the maximum 18-month COBRA continuation period.

If an eligible individual wishes to continue the coverage, he or she must apply, in writing, to the medical carrier no later than 30 days before the end of the COBRA continuation period.

Cost of continuation coverage

The cost of the continuation coverage will:

1. Include any portion previously paid by the employer and shall not be more than 102 percent of the applicable group rate during the period of basic COBRA coverage; or
2. Not be more than 150 percent anytime during the 11-month

disability extension period (for example, during the 19th through the 29th month); or

3. Not be more than 213 percent during the extension period allowed by California continuation coverage.

For information on open enrollment actions for which a qualified beneficiary may be eligible and/or any applicable Plan modifications and premium adjustment, contact the University of the California Human Resources and Benefits toll free at **1-800-888-8267** during the month of November.

Note: When your continuation of coverage ends, you may be eligible to convert your coverage to Individual Plan Membership.

Conversion of Group Membership to an Individual Plan

Your Group is required to inform the Subscriber of the date your coverage ends (please check with your Group's Benefits Administrator to confirm your Membership termination date). 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 through one of our Individual Plans. Individual (Conversion) Plan coverage begins when your Group coverage ends. The Dues and coverage under our Individual (Conversion) Plans are different from those under this *DF/EOC.*

■ How to convert

If you no longer qualify as a Member described in the "Who is eligible" section, we will automatically convert your Group Membership to our *Senior Advantage Individual Plan Agreement* if you still meet the eligibility requirements for Senior Advantage and have not disenrolled.

If you are no longer eligible for Senior Advantage and Group coverage, you may be eligible to convert to a non-Medicare individual Plan, called "Kaiser Permanente Individual (Conversion) Plan." You may be eligible to enroll in our Individual (Conversion) Plan if you apply within 63 days after your Membership terminates.

Call our Member Service Call Center toll free at **1-800-443-0815 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** for more information.

Coverage for disabling condition if your Group's *Agreement* terminates

If you became totally disabled after December 31, 1977, 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, coverage for your disabling condition will continue until any one of the following events occur:

- 12 months have elapsed;
- You are no longer disabled; or
- 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 *DF/EOC,* including Copayments and Coinsurance.

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 Call Center within 30 days of the date the University’s *Group Agreement* with us terminates.

SECTION THREE

General Information for All Members

Kaiser Permanente

Disclosure Form and

Evidence of Coverage

for the

University of California

Effective January 1, 2004

Member Service Call Center

1-800-464-4000
7 a.m. to 7 p.m., seven days a week

Hearing and speech impaired
1-800-777-1370 (TTY)

www.members.kp.org

SECTION THREE

General Information for All Members

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Miscellaneous Provisions

Administration of *Agreement*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the *Group Agreement* and this *DF/EOC.*

Advance directives

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

- 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 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 made a part of your medical chart.

For additional information about advance directives, including how to obtain forms and instructions, contact your local Member Services Department at a Plan Facility.

Agreement binding on Members

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

Amendment of *Agreement*

The University's *Group Agreement* with us will change periodically. If the changes affect this *DF/EOC,* revised materials will be made available to you.

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 *DF/EOC.*

Assignment

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

Attorney fees and expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

Governing law

Except as preempted by federal law, this *DF/EOC* will be governed in accord with California law and any provision required to be in this *DF/EOC* by state or federal law shall bind Member and Health Plan whether or not set forth in this *DF/EOC.*

Group and Members not Health Plan's agents

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

Health Insurance Counseling and Advocacy Program (HICAP)

For additional information concerning covered benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. HICAP provides health insurance counseling for California senior citizens. Call the HICAP toll-free telephone number, **1-800-434-0222 (1-800-722-3140 TTY),** for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

Named fiduciary

Under our *Agreement* with the University, we have assumed the role of a "named fiduciary," a party responsible for determining whether you are entitled to benefits under this *DF/EOC.* Also, as a named fiduciary, we have the discretionary authority to review and evaluate claims that arise under this *DF/EOC.* We conduct this evaluation independently by interpreting the provisions of this *DF/EOC.*

No waiver

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

Nondiscrimination

We do not discriminate in our employment practices or in the delivery of Services on the basis of age, race, color, national origin, cultural background, religion, sex, sexual orientation, or physical or mental disability.

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 Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** or Social Security toll free at **1-800-772-1213** as soon as possible to provide their new address. If a Member does not reside with the Subscriber, he or she should contact our Member Service Call Center to discuss alternate delivery options.

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 (PHI). We also require contracting providers to protect your PHI. PHI is health information that includes your name, Social Security number, or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, and health care operations purposes, including health research and measuring the quality of care and Services. We are sometimes required by law to give PHI to government agencies or in judicial

actions. In addition, Member-identifiable medical information is shared with employers only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI 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* describing our policies and procedures for preserving the confidentiality of medical records and other PHI is available and will be furnished to you upon request. To request a copy, please call our Member Service Call Center toll free at 1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week. You can also find the notice at your local Plan Facility or on our Web site at *www.members.kp.org*.

Definitions

The following terms, when capitalized and used in any part of this *DF/EOC,* mean:

Charges: Charges means the following:

- For Services for which the provider is compensated on a capitation basis, the Charges in the provider's schedule of Charges for Services provided to the general public (or, for Members, the provider's schedule of Charges for Services provided to Members, if different).
- For items covered under "Drugs, supplies, and supplements" and 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 made for the Services.

Clinically Stable: You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

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

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service as listed in the "Copayments and Coinsurance" section.

Copayment: A specific dollar amount that you must pay when you receive a covered Service as listed in the "Copayments and Coinsurance" section.

Dependent: A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who is eligible").

Dues: Periodic Membership Charges paid by Group.

Emergency Care: Emergency Care is:

- Evaluation by a physician (or other appropriate personnel under the supervision of a physician to the extent provided by law).
- Medically Necessary Services required to make you Clinically Stable within the capabilities of the facility.
- Emergency ambulance Services covered under "Ambulance Services" in the "Benefits" section.

Emergency Medical Condition: An Emergency Medical Condition is:

- A medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence

of immediate medical attention to result in any of the following:

- serious jeopardy to your health;
- serious impairment to your bodily functions; or
- serious dysfunction of any bodily organ or part.

- "Active labor," which means a labor when there is inadequate time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the Member or unborn child.

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

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

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

Medical Group: The Permanente Medical Group, Inc., in the Northern California Region, or the Southern California Permanente Medical Group in the Southern California Region, 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: A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Medicare+Choice organization and plan: A Medicare+Choice (M+C) organization is a public or private entity organized and licensed by a state as a risk-bearing entity that has a contract with CMS and meets the M+C requirements. A Medicare+Choice plan is health care coverage offered by a Medicare+Choice organization that includes a specific set of benefits, Dues, and Copayments offered on the same basis to all Medicare beneficiaries residing in the service area of the M+C plan.

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

Out-of-Area Urgent Care: An urgent care need requires prompt medical attention, but is not an Emergency Medical Condition. Out-of-Area Urgent Care is Medically Necessary Services you receive from a non-Plan Provider for an unforeseen illness or injury if all of the following is true:

- You are temporarily outside of our Service Area;
- The Services are necessary to prevent serious deterioration of your health; and
- Treatment cannot be delayed until you return to our Service Area.

Plan: Kaiser Permanente.

Plan Facility: Any facility listed in the "Plan Facilities" section or in one of the

Guidebooks for our Service Area, except that Plan Facilities are subject to change at any time without notice. If you have any questions about the current locations of Plan Facilities, please call our Member Service Call Center.

Plan Hospital: Any hospital listed in the "Plan Facilities" section or in one of the *Guidebooks* for our Service Area, except that Plan Hospitals are subject to change at any time without notice. If you have any questions about the current locations of Plan Hospitals, please call our Member Service Call Center.

Plan Medical Office: Any medical office listed in the "Plan Facilities" section or in one of the *Guidebooks* for our Service Area, except that Plan Medical Offices are subject to change at any time without notice. If you have any questions about the current locations of Plan Medical Offices, please call our Member Service Call Center.

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. If you have any questions about the current locations of Plan Pharmacies, please call our Member Service Call Center.

Plan Physician: Any licensed physician who is an employee of 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, Plan Physician, Medical Group, Plan Pharmacy, or other health care provider that we designate as a Plan Provider.

Post-stabilization Care: Post-stabilization Care is the Services (including transportation) you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable, or after you obtain covered Out-of-Area Urgent Care. Post-stabilization Care can be provided while you are still in a hospital Emergency Department, after you have been admitted to a hospital, or in another setting.

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 Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington, please call our Member Service Call Center.

Services: Health care Services or items.

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 and approved by Health Plan. 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 a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility as long as it continues to meet the definition above.

Spouse: Your legal husband or wife. For the purposes of this *DF/EOC,* the term "Spouse" includes your domestic partner, in accord with your Group's requirements that we approve in writing.

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 the "Who is eligible" section of the applicable *DF/EOC*).

Service Area

Northern California Service Area—Kaiser Permanente Traditional Plan

The following counties are entirely within our Northern California Traditional Plan Service Area: Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, San Mateo, Solano, and Stanislaus. Portions of the following counties, as indicated by the ZIP codes below, are also inside this Service Area:

Amador: 95640, 95669

El Dorado: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762

Fresno: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–22, 93724–29, 93740–41, 93744–45, 93747, 93750, 93755, 93760–62, 93764–65, 93771–80, 93784, 93786, 93790–94, 93844, 93888

Kings: 93230, 93232, 93242, 93631, 93656

Madera: 93601–02, 93604, 93614, 93623, 93626, 93637–39, 93643–45, 93653, 93669

Mariposa: 93601, 93623, 93653

Napa: 94503, 94508, 94515, 94558–59, 94562, 94567*, 94573–74, 94576, 94581, 94585, 94589–90, 94599

Placer: 95602–04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95692, 95703, 95722, 95736, 95746–47, 95765

Santa Clara: 94022–24, 94035, 94039–43, 94085–90, 94301–06, 94309–10, 94550, 95002, 95008–09, 95011, 95013–15, 95020**–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95101–03, 95106, 95108–42, 95148, 95150-61, 95164, 95170-73, 95190-94, 95196

Sonoma: 94515, 94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–09, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, 95492

Sutter: 95645, 95659, 95668, 95674, 95676, 95692, 95837

Tulare: 93618, 93646, 93654, 93666, 93673

Yolo: 95605, 95607, 95612, 95616–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99

Yuba: 95692, 95903, 95961.

* The Knoxville community, which lies within Pope Valley ZIP code 94567, is not in the Service Area.

** The Bells Station community, which lies within Gilroy ZIP code 95020, is not in the Service Area.

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

Southern California Service Area–Kaiser Permanente Traditional Plan

The following counties are entirely within our Southern California Traditional Plan Service Area: Orange and Los Angeles (except ZIP code 90704**). Portions of the following counties, as indicated by the ZIP codes below, are also inside our Service Area:

Imperial: 92274–75*

Kern: 93203, 93205–06, 93215–16, 93220, 93222, 93224–26, 93238, 93240–41, 93243, 93250–52, 93263, 93268, 93276, 93280, 93285, 93287, 93301–09, 93311–14, 93380–90, 93501–02, 93504–05, 93518–19, 93531, 93536, 93560–61, 93581

Riverside: 91752, 92201–03*, 92210–11*, 92220, 92223, 92230*, 92234–36*, 92240–41*, 92253–55*, 92258*, 92260–64*, 92270*, 92274*, 92276*, 92282*, 92292*, 92320, 92324, 92373, 92399, 92501–09, 92513–19, 92521–22, 92530–32, 92543–46, 92548, 92551–57, 92562–64, 92567, 92570–72, 92581–87, 92595–96, 92599, 92860, 92877–83

San Bernardino: 91701, 91708–10, 91729–30, 91737, 91739, 91743, 91758, 91761–64, 91766, 91784–86, 91798, 92252*, 92256*, 92268*, 92277–78*, 92284–86*, 92305, 92307–08, 92313–18, 92321–22, 92324–26, 92329, 92333–37, 92339–41, 92345–46, 92350, 92352, 92354, 92357–59, 92369, 92371–78, 92382, 92385–86, 92391–94, 92397, 92399, 92401–08, 92410–15, 92418, 92420, 92423–24, 92427, 92880

San Diego: 91901–03, 91908–17, 91921, 91931–33, 91935, 91941–47, 91950–51, 91962–63, 91976–80, 91987, 91990, 92007–09, 92013–14, 92018–27, 92029–30, 92033, 92037–40, 92046, 92049, 92051–52, 92054–58, 92064–65, 92067–69, 92071–72, 92074–75, 92078–79, 92081–85, 92090–93, 92096, 92101–24, 92126–40, 92142–43, 92145, 92147, 92149–50, 92152–55, 92158–79, 92182, 92184, 92186–87, 92190–99

Tulare: 93238, 93261

Ventura: 90265, 91304, 91307, 91311, 91319–20, 91358–62, 91377, 93001–07*, 93009*, 93010–12, 93015–16, 93020–21, 93022*, 93030–36*, 93040, 93041–44*, 93060–61*, 93062–66, 93093–94, 93099.

*Subscribers residing in Coachella Valley and western Ventura County ZIP codes are required to select a primary care Plan Physician (Affiliated Physician). Please refer to “Your primary care Plan Physician” in the “How to Obtain Services” section for details.

**Avalon, Catalina Island is not in the Service Area.

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

Northern California Group Plan Service Area—Kaiser Permanente Senior Advantage

The following counties are entirely within our Senior Advantage Northern California Group Plan Service Area: Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, San Mateo, Solano, and Stanislaus. Portions of the following counties, as indicated by the ZIP codes below, are also within this Service Area:

Amador: 95640, 95669

El Dorado: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762

Fresno: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–22, 93724–29, 93740–41, 93744–45, 93747, 93750, 93755, 93760–62, 93764–65, 93771–80, 93784, 93786, 93790–94, 93844, 93888

Kings: 93230, 93232, 93242, 93631, 93656

Madera: 93601–02, 93604, 93614, 93623, 93626, 93637–39, 93643–45, 93653, 93669

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Yolo: 95605, 95607, 95612, 95616–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99

Yuba: 95692, 95903, 95961.

* The Knoxville community, which lies within Pope Valley ZIP code 94567, is not in the Service Area.

** The Bells Station community, which lies within Gilroy ZIP code 95020, is not in the Service Area.

Note: Subject to approval by the Centers for Medicare & Medicaid Services (CMS), we may reduce our Service Area effective any January 1 by giving prior written notice to your Group.

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

Southern California Group Plan Service Area—Kaiser Permanente Senior Advantage

The following counties are entirely within our Senior Advantage Southern California Group Plan Service Area: Orange and Los Angeles (except ZIP code 90704**). Portions of the following counties, as indicated by the ZIP codes below, are also within this Service Area:

Kern: 93203, 93205–06, 93215–16, 93220, 93222, 93224–26, 93238, 93240–41, 93243, 93250–52, 93263, 93268, 93276, 93280, 93285, 93287, 93301–09, 93311–14, 93380–90, 93501–02, 93504–05, 93518, 93531, 93536, 93560–61, 93581

Riverside: 91752, 92201–03*, 92210–11*, 92220, 92223, 92230*, 92234–36*, 92240–41*, 92253*, 92255*, 92258*, 92260–64*, 92270*, 92276*, 92282*, 92292*, 92320, 92324, 92373, 92399, 92501–09, 92513–19, 92521–22, 92530–32, 92543–46, 92548, 92551–57, 92562–64, 92567, 92570–72, 92581–87, 92595–96, 92599, 92860, 92877–83

San Bernardino: 91701, 91708–10, 91729–30, 91737, 91739, 91743, 91758, 91761–64, 91766, 91784–86, 91798, 92305, 92307–08, 92313–18, 92321–22, 92324–26, 92329, 92333–37, 92339–41, 92345–46, 92350, 92352, 92354, 92357–59, 92369, 92371–78, 92382, 92385–86, 92391–94, 92397, 92399, 92401–08, 92410–15, 92418, 92420, 92423–24, 92427, 92880

San Diego: 91901–03, 91908–17, 91921, 91931–33, 91935, 91941–47, 91950–51, 91962–63, 91976–80, 91987, 91990, 92007–09, 92013–14, 92018–27, 92029–30, 92033, 92037–40, 92046, 92049, 92051–52, 92054–58, 92064–65, 92067–69, 92071–72, 92074–75, 92078–79, 92081–85, 92090–93, 92096, 92101–24, 92126–40, 92142–43, 92145, 92147, 92149–50, 92152–55, 92158–79, 92182, 92184, 92186–87, 92190–99

Tulare: 93238, 93261

Ventura: 91304, 91307, 91311, 91319–20, 91358–62, 91377, 93010–12, 93015–16, 93020–21, 93040, 93062–66, 93093–94, 93099.

*Subscribers residing in Coachella Valley ZIP codes are required to select a primary care Plan Physician (Affiliated Physician). Please refer to "Your primary care Plan Physician" in the "How to Obtain Services" section for details.

**Avalon, Catalina Island is not in the Service Area.

Note: Subject to approval by the Centers for Medicare & Medicaid Services (CMS), we may reduce our Service Area effective any January 1 by giving prior written notice to your Group.

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

Plan Administration

By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this Plan in accordance with applicable Plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in the source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this booklet is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this booklet and/or the *Group Medical and Hospital Service Agreement.* What is written in this booklet does not constitute a guarantee of Plan coverage or benefits—particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

This section describes how the Plan is administered and what your rights are.

Sponsorship and administration of the Plan

The University of California is the Plan sponsor and administrator for the Plan described in this booklet. If you have a question, you may direct it to:

University of California
Human Resources and Benefits
300 Lakeside Drive, Fifth Floor
Oakland, CA 94612–3557

1-800-888-8267

Annuitants may also direct questions to the University's Customer Service Center at the above phone number.

Claims under the Plan are processed by Kaiser Foundation Health Plan, Inc., at the following locations:

Northern California Members:

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

510-987-1400 or **1-800-464-4000**

Southern California Members:

Kaiser Foundation Health Plan, Inc.
Claims Administration Department
P.O. Box 7102
Pasadena, CA 91109-9880

1-800-390-3510

Group contract number for Northern California Members

The group contract number for University of California, Northern California, is Group 7.

Group contract numbers for Southern California Members

The group contract numbers for University of California, Southern California, are Groups 102601, 102602, 102603, 102604, 102605, 102607, 102608, 102610, 102611, 102624, and 102625.

Type of Plan

This Plan is a health and welfare plan that provides group medical care benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

Plan year

The Plan year is January 1 through December 31.

Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet, but reserves the right to terminate or amend it at any time. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all employees, Annuitants, and Plan beneficiaries. The amendment or termination shall be carried out by the president or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums, and what portion of the premiums the University will pay. The portion of the premium the University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.

Financial arrangements

The benefits under the Plan are provided or arranged for by Kaiser Foundation Health Plan, Inc., a federally qualified health maintenance organization providing health care under a *Group Agreement.*

Agent for serving of legal process

Legal process may be served on Kaiser Foundation Health Plan, Inc., at the following address:

Northern California Members:

Kaiser Foundation Health Plan, Inc.
Legal Department
P.O. Box 12916
Oakland, CA 94604

Southern California Members:

Kaiser Foundation Health Plan, Inc.
Legal Department
393 E. Walnut St.
Pasadena, CA 91188

Your rights under the Plan

As a participant in a University of California medical Plan, you are entitled to certain rights and protections.

All Plan participants shall be entitled to:

- Examine, without charge, at the Plan administrator's office, and other specified sites, all Plan documents, including the *Group Agreement,* at a time and location mutually convenient to the participant and the Plan administrator.
- Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan administrator.

Claims under the Plan

To file a claim or to appeal a denied claim, refer to the applicable "Dispute Resolution" section of this *DF/EOC.*

Nondiscrimination statement

In conformance with applicable law and University policy, the University of

California is an affirmative action/equal opportunity employer.

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to:

Director Mattie L. Williams
University of California
Office of the President
300 Lakeside Drive
Oakland, CA 94612

and for faculty to:

Executive Director Sheila O'Rourke
University of California
Office of the President
1111 Franklin St.
Oakland, CA 94607

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