KAISER PERMANENTE®

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

Kaiser Permanente Senior Advantage

Disclosure Form and Evidence of Coverage for the University of California

Kaiser Foundation Health Plan, Inc.
Northern California and Southern California Regions
Effective January 1, 2005

KAISER PERMANENTE®

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2005 Summary of Changes and Clarifications

The following is a summary of the most important changes and clarifications that we have made to this 2005 *Disclosure Form and Evidence of Coverage (DF/EOC)*.

Please refer to in either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage, in this *DF/EOC* for benefit descriptions and the amount Members must pay for covered benefits. Benefits are also subject to the "Emergency, Urgent, and Routine Care" and the "Exclusions, Limitations, and Reductions" sections.

Changes

Group appointments

Some group appointments will be covered at half the Copayment that applies to an individual office visit (rounded down to the nearest whole dollar). A group medical appointment meets under the direction of a Plan Provider and it provides an opportunity to integrate clinical services, education, and support for a group of patients with a similar condition. Some examples of conditions that lend themselves to group medical appointments include maintenance of asthma, diabetes, and chronic pain.

Imaging and special procedures

Imaging and special procedures will be covered at the same Copayment as for outpatient surgery, if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors the Member's vital signs as the Member regains sensation after receiving drugs to reduce sensation or to minimize discomfort. Some examples of special procedures include colonoscopy and interventional radiology procedures.

Clarifications

Continuation of membership

If Members want to continue their membership under our Individual–Conversion Plan or Cal-COBRA group continuation coverage, they must submit their application to us within 63 days either after the Member receives our termination letter or after their termination effective date, whichever is later.

Emergency, post-stabilization, and urgent care

We have clarified the "Emergency, Post-stabilization, and Urgent Care" section to more clearly describe when Post-stabilization Care and transportation are covered, and that Post-stabilization Care follows an Emergency Medical Condition but not urgent care. We have also revised the definition for Out-of-Area Urgent Care to include pregnancies in accord with recent California regulations.

Kaiser Permanente Senior Advantage

Senior Advantage eligibility requirements have been clarified to reflect the current practice that allows enrollment of Members without Medicare Part A. Persons without Medicare Part A may enroll upon payment of the applicable Dues by Group. Also, the Centers for Medicare & Medicaid Services (CMS) has changed the name of its Medicare contracts from Medicare+Choice to Medicare Advantage.

Benefit Summary for Kaiser Permanente Senior Advantage

Annual Out-of-Pocket Maximum	
For one Member	$1,500 per calendar year
For an entire Family Unit	$3,000 per calendar year
Deductible or Lifetime Maximum	None
Professional Services (Plan Provider Office Visits)	**You Pay**
Primary and specialty care visits (includes routine and urgent care appointments)	$10 per visit
Routine physical exams	$10 per visit
Well-child preventive care visits to age 2	No charge
Family planning visits	$10 per visit
Scheduled prenatal care and first postpartum visit	No charge
Eye exams and glaucoma screening	$10 per visit
Hearing tests	$10 per visit
Physical, occupational, and speech therapy visits	$10 per visit
Outpatient Services	**You Pay**
Outpatient surgery	$10 per procedure
Allergy injection visits	$3 per visit
Allergy testing visits	$10 per visit
Immunizations	No charge
X-rays, annual mammograms, and lab tests	No charge
Manual manipulation of the spine	$10 per visit
Health education	$10 per visit No charge for group visits
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	$250 per admission
Emergency Health Coverage	**You Pay**
Emergency Department and Out-of-Area Urgent Care visits	$50 per visit (waived if admitted to the hospital as an inpatient within 24 hours for the same condition)
Ambulance Services	**You Pay**
Ambulance Services	No charge
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary when obtained at Plan Pharmacies:	
Generic items	$10 for up to a 100-day supply
Brand-name items	$20 for up to a 100-day supply

Durable Medical Equipment	You Pay
Covered durable medical equipment in accord with our DME formulary	No charge

Mental Health Services	You Pay
Inpatient psychiatric care (first 190 days per lifetime as covered by Medicare)	$250 per admission
Outpatient visits:	
Individual and group therapy visits	$10 per individual therapy visit $5 per group therapy visit
Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the "Benefits, Copayments, and Coinsurance for Senior Advantage" section.	

Chemical Dependency Services	You Pay
Inpatient detoxification	$250 per admission
Outpatient individual therapy visits	$10 per visit
Outpatient group therapy visits	$5 per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission

Home Health Services	You Pay
Home health care (part-time, intermittent)	No charge

Other	You Pay
Eyewear purchased from Plan optical sales offices every 24 months	$150 Allowance
Hearing aid(s) every 36 months	$2,500 Allowance per aid
Skilled Nursing Facility care (up to 100 days per benefit period)	No charge
Hospice care	No charge

This is a summary of the most frequently asked about benefits and their Copayments and Coinsurance. This chart does not describe benefits. To learn what is covered for each benefit (including exclusions and limitations) and additional benefits that are not included in this summary, please refer to the "Benefits, Copayments, and Coinsurance for Senior Advantage" section. Also, exclusions, limitations, and reductions that apply to all benefits are described in the "Exclusions, Limitations, and Reductions" section.

Benefit Summary for Kaiser Permanente Senior Advantage MSP

Annual Out-of-Pocket Maximum	
For one Member	$1,500 per calendar year
For an entire Family Unit	$3,000 per calendar year
Deductible or Lifetime Maximum	None
Professional Services (Plan Provider Office Visits)	**You Pay**
Primary and specialty care visits (includes routine and urgent care appointments)	No charge
Routine physical exams	No charge
Well-child preventive care visits to age 2	No charge
Family planning visits	No charge
Scheduled prenatal care and first postpartum visit	No charge
Eye exams and glaucoma screening	No charge
Hearing tests	No charge
Physical, occupational, and speech therapy visits	No charge
Outpatient Services	**You Pay**
Outpatient surgery	No charge
Allergy injection visits	No charge
Allergy testing visits	No charge
Immunizations	No charge
X-rays, annual mammograms, and lab tests	No charge
Manual manipulation of the spine	No charge
Health education	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	No charge
Emergency Health Coverage	**You Pay**
Emergency Department and Out-of-Area Urgent Care visits	No charge
Ambulance Services	**You Pay**
Ambulance Services	No charge
Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary when obtained at Plan Pharmacies	No charge for up to a 100-day supply
Durable Medical Equipment	**You Pay**
Covered durable medical equipment in accord with our DME formulary	No charge

Mental Health Services	You Pay
Inpatient psychiatric care (first 190 days per lifetime as covered by Medicare)	No charge
Outpatient visits:	
Individual and group therapy visits	No charge
Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section.	

Chemical Dependency Services	You Pay
Inpatient detoxification	No charge
Outpatient individual therapy visits	No charge
Outpatient group therapy visits	No charge
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	No charge

Home Health Services	You Pay
Home health care (part-time, intermittent)	No charge

Other	You Pay
Eyewear purchased from Plan optical sales offices every 24 months	$350 Allowance
Hearing aid(s) every 36 months	$2,500 Allowance per aid
Skilled Nursing Facility care	No charge
Hospice care	No charge

This is a summary of the most frequently asked about benefits and their Copayments and Coinsurance. This chart does not describe benefits. To learn what is covered for each benefit (including exclusions and limitations) and additional benefits that are not included in this summary, please refer to the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section. Also, exclusions, limitations, and reductions that apply to all benefits are described in the "Exclusions, Limitations, and Reductions" section.

Introduction

Kaiser Foundation Health Plan, Inc., has a contract with the Centers for Medicare & Medicaid Services (CMS) as a Medicare Advantage organization, which is renewed annually. This contract provides Medicare Services through Kaiser Permanente Senior Advantage (Senior Advantage), except for hospice care for Members with Medicare Parts A and B and qualifying clinical trials, which are covered directly by Medicare. Senior Advantage is for Members entitled to Medicare, providing the advantages of combined Medicare and Health Plan benefits.

This *Disclosure Form and Evidence of Coverage (DF/EOC)* describes the Senior Advantage (when Medicare is primary) and the Senior Advantage MSP (when Medicare is secondary under federal law) health care coverage provided under the *Agreement* between Kaiser Foundation Health Plan, Inc. (Northern California Region and Southern California Region), and the University of California (Group). Medicare is the primary coverage except when federal law requires that your Group's health care plan be primary and Medicare coverage be secondary. 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." Some capitalized terms have special meaning in this *DF/EOC;* please see the "Definitions" section for terms you should know.

Please read the following information so that you will know from whom or what group of providers you may get health care. It is important to familiarize yourself with your coverage by reading this *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.

Term of this *DF/EOC*

This *DF/EOC* is for the period January 1, 2005, through December 31, 2005, unless amended. Your Group's benefits administrator can tell you whether this *DF/EOC* is still in effect and give you a current one if this *DF/EOC* has expired or been amended.

About Kaiser Permanente

Kaiser Permanente provides Services directly to our Members through an integrated medical care program. Our Health Plan, 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 either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage. Plus, our preventive care programs and health education classes offer you and your family great ways to protect and improve your health.

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

- Getting a referral, in the "How to Obtain Services" section
- Visiting other Regions, in the "How to Obtain Services" section
- Emergency Care, Post-stabilization Care, and Out-of-Area Urgent Care, in the

"Emergency, Urgent, and Routine Care" section
- Emergency ambulance Services described under "Ambulance Services" in either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage
- Out-of-area dialysis care described under "Dialysis Care" in either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage

Note: Most of the covered Services that Senior Advantage MSP Members receive under this *DF/EOC* will be provided to them at no charge because they are covered by their Group as primary coverage and by Medicare as secondary coverage.

Definitions

The following terms, when capitalized and used in any part of this *DF/EOC*, mean:

Allowance: A credit that you can use toward the purchase price of an item. If the price of the item(s) you select exceeds the allowance, you will pay the difference.

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

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 described in either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage.

Copayment: A specific dollar amount that you must pay when you receive a covered Service as described in either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage. Note:

The dollar amount of the Copayment can be $0 (no charge).

Deductible: The amount you must pay in a calendar year for certain Services before we will cover those Services at the Copayment or Coinsurance in that calendar year.

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

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 either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage

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
  - 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., a for-profit professional corporation in the Northern California Region, or the Southern California Permanente Medical Group, a for-profit professional partnership in the Southern California Region.

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 age 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Medicare Advantage organization and plan: A Medicare Advantage 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 Medicare Advantage requirements. A Medicare Advantage plan is health care coverage offered by a Medicare Advantage 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 Medicare Advantage 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."

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

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

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

Out-of-Area Urgent Care: 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 are true:

- You are temporarily outside our Service Area
- The Services are necessary to prevent serious deterioration of your health
- 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 (Your Guidebook to Kaiser Permanente Services)* 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 (Your Guidebook to Kaiser Permanente Services)* 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 (Your Guidebook to Kaiser Permanente Services)* 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 to Kaiser Permanente Services* 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 or partner 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 Medically Necessary Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable.

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.

Retiree: A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

Service Area:

Northern California Region Service Area

The following counties are entirely inside our 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 our 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, 93618-19, 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, 93720
- **Mariposa:** 93601, 93623, 93653
- **Napa:** 94503, 94508, 94515, 94558-59, 94562, 94567*, 94573-74, 94576, 94581, 94589-90, 94599, 95476
- **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:** 93238, 93261, 93618, 93646, 93654, 93666, 93673
- **Yolo:** 95605, 95607, 95612, 95616-18, 95645, 95691, 95694-95, 95697-98, 95776, 95798-99
- **Yuba:** 95692, 95903, 95961

*Exception: The communities of Bells Station and Knoxville are not in our Service Area.

Southern California Region Service Area

The following counties are entirely inside our 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:

- **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*, 92247-48*, 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, 92391-95, 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
- **Ventura:** 90265, 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.

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

Services: Health care services or items.

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 (for example, a Plan Hospital) 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 registered domestic partner who meets all the requirements of Section 297 of the California Family Code, or 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 "Who Is Eligible" in the "Dues, Eligibility, and Enrollment" section).

Survivor: A deceased Employee's or Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan.

Dues, Eligibility, and Enrollment

Dues

Your Group is responsible for paying Dues. If you are responsible for any contribution to the Dues, your Group will tell you the amount and how to pay 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.

Who Is Eligible

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

The University of California establishes its own medical plan eligibility, enrollment, and termination criteria based on the University of California Group Insurance Regulations ("Regulations") and any corresponding Administrative Supplements. Portions of these Regulations are summarized below.

Note: References to Employee in this section applies only to Senior Advantage MSP Members.

Group eligibility requirements

You must meet the University of California's eligibility requirements that we have approved. Your Group is required to inform Subscribers of its eligibility requirements, such as the minimum number of hours that employees must work. Please note that the University might not allow enrollment to some persons who meet the requirements described under "Service Area eligibility requirements."

Medicare eligibility requirements

- You must be entitled to benefits under Medicare Part B
- You may enroll in Senior Advantage regardless of health status, except that you may not enroll if you have end-stage renal disease. This restriction does not apply to you if you are currently a Health Plan Member in the Northern California or Southern California Region and you developed end-stage renal disease while a Member
- 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
- For Senior Advantage MSP Members, your Group's health care plan must be primary and Medicare coverage must be secondary under federal law
- Non-Members may not be able to enroll if Senior Advantage 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 (for example, when you turn age 65)

Service Area eligibility requirements

The Subscriber must live in our Service Area. However, if you were enrolled in Senior Advantage on December 31, 1998, and lived outside our Service Area, you may continue your membership unless you move and are still outside our Service Area. The "Definitions" section describes our Service Area and how it may change.

Moving outside our Service Area. If you permanently move outside our Service Area, or you are temporarily absent from our Service Area for a period of more than six months, you must notify us and you cannot continue your Senior Advantage membership under this *DF/EOC*. Send your notice to:

Northern California Region Members:
Kaiser Permanente
California Service Center
P.O. Box 232400
San Diego, CA 92193

Southern California Region Members:
Kaiser Permanente
California Service Center
P.O. Box 232407
San Diego, CA 92193

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 from Non-Plan Providers, except as described in the following sections about:

- Getting a referral, in the "How to Obtain Services" section
- Visiting other Regions, in the "How to Obtain Services" section
- Emergency Care, Post-stabilization Care, and Out-of-Area Urgent Care, in the "Emergency, Urgent, and Routine Care" section
- Emergency ambulance Services described under "Ambulance Services" in either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage
- Out-of-area dialysis care described under "Dialysis Care" in either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage

If you move to the service area of another Region, 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. For information about Region locations and telephone numbers in the District of Columbia, Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington, please call our Member Service Call Center.

If you live in or move to the other California Region's Service Area, please contact your Group's benefits administrator to learn about your Group health care options.

Subscriber

Employee. You are eligible if you are appointed to work at least 50% time for twelve months or more or are appointed at 100% time for three months or more or have accumulated 1,000***** hours while on pay status in a twelve (12)-month period. To remain eligible, you must maintain an average regular paid time****** of at least 17.5 hours per week and continue in an eligible appointment. If your appointment is at least 50% 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)."

* Lecturers - see your Benefits Office for eligibility.

** For any month, your average regular paid time is the average number of regular paid hours per week (excluding overtime, stipend, or bonus time) worked by you in the preceding twelve (12)-month period.

(a) A month with zero regular paid hours that occurred during your furlough or approved leave without pay will not be included in the calculation of the average. If such absence exceeds eleven (11) months, the averaging will be restarted.

(b) A month with zero regular paid hours that occurred during a period when you were not on furlough or approved leave without pay will be included in the calculation of the average. After two consecutive such months, the averaging will be restarted.

For a partial month of zero regular paid hours due to furlough, leave without pay, or initial employment the following will apply:

(a) If you worked at least 43.75% of the regular paid hours available in the month, the month will be included in the calculation of the average.

(b) If you did not work at least 43.75% of the regular paid hours available in the month,

the month will not be included in the calculation of the average.

Retiree (including Survivor)

Retiree. A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

Survivor. A deceased Employee's or Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan.

You may continue University medical plan coverage as a Retiree when you start collecting retirement or disability benefits from a University-sponsored defined benefit plan, or as a Survivor when you start collecting survivor benefits from a University-sponsored defined benefit plan. You must also meet the following requirements:

(a) you meet the University's service credit requirements for Retiree medical eligibility;
(b) the effective date of your Retiree status is within 120 calendar days of the date employment ends (or the date of the Employee/Retiree's death for a Survivor); and
(c) you elect to continue medical coverage at the time of retirement.

If you are eligible for Medicare, see "Effect of Medicare on Retiree enrollment".

Eligible Dependents (Family Members)

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. We and the University reserve the right to periodically request documentation to verify eligibility of Family Members including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), adoption records, federal income tax return, or other official documentation.

Spouse. Your legal Spouse.

Child. All eligible children must be under the limiting age (18 for legal wards, 23 for all others), unmarried, and may not be emancipated minors. The following categories are eligible:

(a) your natural or legally adopted children;
(b) your stepchildren (natural or legally adopted children of your Spouse) if living with you, dependent on you or your Spouse for at least 50% of their support and are your or your Spouse's dependents for income tax purposes;
(c) grandchildren of you or your Spouse if living with you, dependent on you or your Spouse for at least 50% of their support and are your or your Spouse's dependents for income tax purposes;
(d) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental handicap may continue to be covered past age 23 provided:

- the incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous;
- the child is claimed as your dependent for income tax purposes or is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment that may offset the Social Security or Supplemental Security Income; and

- the child lives with you if he or she is not your or your Spouse's natural or adopted child.

We must receive your application at least 31 days before the child's 23rd birthday and we must approve the application. We may periodically request proof of continued disability. 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 incapacitated child, you may also apply for coverage for that child. The child must have had continuous group medical coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility (PIE).

Other eligible Dependents (Family Members)

You may enroll a same-sex domestic partner (and the same-sex domestic partner's children/grandchildren/ stepchildren) as set forth in the University of California Group Insurance Regulations.

Effective January 1, 2005, the University will recognize an opposite-sex domestic partner as a Family Member that is eligible for coverage in UC-sponsored benefits if the Employee/Retiree or domestic partner is age 62 or older and eligible to receive Social Security benefits and both the Employee/Retiree and domestic partner are at least 18 years of age.

An adult dependent relative is no longer eligible for coverage effective January 1, 2004. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003, may continue coverage in UC-sponsored plans.

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's Customer Service Center.

No dual coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Survivor, or a Family Member, but not under any combination of these. If an Employee and the Employee's Spouse or domestic partner are both eligible Subscribers, each may enroll separately or one may cover the other as a Family Member. If they enroll separately, neither may enroll the other as a Family Member. Eligible children may be enrolled under either parent's or eligible domestic partner's coverage but not under both. Additionally, a child who is also eligible as an Employee may not have dual coverage through two University-sponsored medical plans.

Persons barred from enrolling

You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for failure to pay individual (nongroup) plan dues, unless we agree to allow you to enroll after you pay all amounts owed by you and your dependents

Effect of Medicare on Retiree enrollment

If you are a Retiree and you and/or an enrolled Family Member is or becomes eligible for premium free Medicare Part A (Hospital Insurance) as primary coverage, then that individual must also enroll in and remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in both Part A and Part B must be continuous. This includes anyone who is entitled to Medicare benefits through their own or their Spouse's non-University employment.

Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan. Beginning January 1, 2004, Retirees or their Family Member(s) who became eligible for premium free Medicare Part A and do not enroll in Part B, will permanently lose their UC-sponsored medical coverage.

Retirees and their Family Members who were eligible for premium free Medicare Part A, but declined to enroll in Part B of Medicare before January 1, 2004, were assessed a monthly offset fee by the University to cover increased costs. The offset fee may increase annually, but will stop when the Retiree or Family Member becomes covered under Part B. Retirees or Family Members who are not eligible for premium free Part A will not be assessed an offset fee nor lose their UC-sponsored medical coverage. Documentation attesting to their ineligibility for Medicare Part A will be required. (Retirees/Family Members who are not entitled to Social Security and premium free Medicare Part A will not be required to enroll in Part B.)

You should contact Social Security three months before your or your Family Member's 65th birthday to inquire about your eligibility and how you enroll in the Hospital (Part A) and Medical (Part B) portions 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.

Upon Medicare eligibility, you or your Family Member must complete a University of California Medicare Declaration form as well as submit a copy of your Medicare card. This notifies the University that you are covered by Part A and Part B of Medicare. The University's Medicare Declaration form is available through the University's Customer Service Center. Completed forms should be returned to: University of California, Human Resources and Benefits, Health & Welfare Administration – Retiree Insurance Program, Post Office Box 24570, Oakland, CA 94623-9911.

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care contract must assign his/her Medicare benefits to that plan or lose UC-sponsored medical coverage.

Medicare is secondary

Medicare Secondary Payer (MSP) laws affect the order in which claims are paid by Medicare and an employer group health plan. UC Retirees hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For Employees or their Spouses who are age 65 or older and eligible for a group health plan due to employment, Medicare becomes the secondary payer and the employer plan becomes the primary payer.

Medicare private contracting provision

Federal legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services **(that would otherwise be covered by Medicare)** from these physicians or practitioners will need to enter into written "private contracts" with these physicians or practitioners requiring the beneficiary to be responsible for all payments to such providers. Services provided under "private contracts" are not covered by Medicare, and the Medicare limiting charge will not apply.

If you are classified as a Retiree by the University (or otherwise have Medicare as a primary coverage) and enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement with one or more physicians or practitioners, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. No benefits will be paid by this

Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered.

However, if you do sign a private contract with a physician or practitioner, you may see other physicians or practitioners without those private contract restrictions as long as they have not opted out of Medicare.

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 (for example, when you turn age 65).

When You Can Enroll and When Coverage Begins

The University of California is required to inform you when you are eligible to enroll and your effective date of coverage. If you are eligible to enroll as described under "Who Is Eligible" in this "Dues, Eligibility, and Enrollment" section, you may enroll yourself and any eligible Dependents by submitting an enrollment application and a Senior Advantage Election Form (one form completed and signed by each Medicare beneficiary) to the University within 31 days.

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are a Retiree, contact the University's Customer Service Center. Enrollment transactions may be completed by paper form or electronically, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits Office or by the University's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

If you are already a Health Plan Member who lives in the Senior Advantage Service Area, we will mail you information about joining Senior Advantage and an Election Form shortly before you reach age 65.

Effective date of Senior Advantage coverage

After we receive your completed Senior Advantage Election Form, 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 Medicare Part B, or if you are already entitled to Medicare Part B.

If you will soon become entitled to Medicare Part B, your election will be effective on the first day of the month in which you are entitled to Medicare Part B. If you are already entitled to Medicare Part 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.

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 Medicare Part 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 that you are still not entitled to Medicare Part B, you will be billed for any Services we have provided you unless you are an existing Member under another Kaiser Permanente plan (for example, Kaiser Permanente Traditional Plan). Members will be responsible for any amounts owed under their other plan and should contact their Group's benefits administrator for details.

During a Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

If you are an Employee, you may enroll yourself and any eligible Family Members during your PIE. Your PIE starts the day you become an eligible Employee.

You may enroll any newly eligible Family Member during his or her PIE. The Family Member's PIE starts the day your Family Member becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other eligible Family Member if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any eligible Family Member. Family members are only eligible for the same plan you are enrolled in.

(a) For a Spouse, on the date of marriage.

(b) For a natural child, on the child's date of birth.

(c) For an adopted child, the earlier of:
   (i) the date you or your Spouse has the legal right to control the child's health care, or
   (ii) the date the child is placed in your physical custody.

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

(d) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you decline enrollment for yourself or your eligible Family Members because of other group medical plan coverage and you lose that coverage involuntarily, you may be able to enroll yourself and those eligible Family Members during a PIE that starts on the day the other coverage is no longer in effect.

If you are in an HMO plan and you move or are transferred out of that 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 yourself and your eligible Family Members in another University medical plan. Your PIE starts with the effective date of the move or the date you leave the plan's service area.

At other times for employees and retirees

You and your eligible Family Members may also enroll during a group open enrollment period established by the University.

If you are an Employee and opt out of medical coverage or fail to enroll yourself during a PIE or open enrollment period, you may enroll yourself at any other time upon completion of a 90 consecutive calendar-day waiting period.

If you are an Employee or Retiree and fail to enroll your eligible Family Members during a PIE or open enrollment period, you may enroll your eligible Family Members 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.

If you have one or more children enrolled, you may add a newly eligible child at any time. See "Effective date."

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan you were enrolled in immediately before retiring. You must elect to continue enrollment for yourself and enrolled Family Members before the effective date of retirement (or the date disability or survivor benefits begin).

If you are a Survivor, you may not enroll your legal Spouse or domestic partner.

Effective date

The following effective dates apply provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

If you enroll during a PIE, coverage for you and your Family Members is effective the date the PIE starts.

If you are a Retiree continuing enrollment in conjunction with retirement, coverage for you and your Family Members is effective on the first of the month following the first full calendar month of retirement income.

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

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment transaction is completed.

An Employee or Retiree already enrolled in adult plus child(ren) or family coverage may add additional children, if eligible, at any time after their PIE. Retroactive coverage is limited to the later of:

(a) the date the child becomes eligible, or
(b) a maximum of 60 days prior to the date your child's enrollment transaction is completed.

Change in coverage

In order to change from single to adult plus child(ren) coverage, or two adult coverage, or family coverage, or to add another child to existing family coverage, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Note: If you have a Medicare supplement (Medigap) policy, you may consider canceling it after we send you written confirmation of your enrollment in Senior Advantage. However, if you later disenroll from Senior Advantage, you may not be able to have your Medigap policy reinstated. 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. For additional information regarding guaranteed Medicare supplemental policies, call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222 (*TTY 1-800-722-3140*).

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:

- Getting a referral, in this section
- Visiting other Regions, in the "How to Obtain Services" section
- Emergency Care, Post-stabilization Care, and Out-of-Area Urgent Care, in the "Emergency, Urgent, and Routine Care" section

- Emergency ambulance Services described under "Ambulance Services" in either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage
- Out-of-area dialysis care described under "Dialysis Care" in either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage

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 either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage.

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, family medicine, and pediatrics. Also, women can select any available primary care Plan Physician from obstetrics/gynecology. You can change your primary care Plan Physician for any reason. To learn how to select a primary care Plan Physician, please call our Member Service Call Center. You can find a directory of our Plan Physicians on our Web site at *www.kaiserpermanente.org*.

Special note about Coachella Valley

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 the "Definitions" section 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 that women can get annual mammograms and visits to their obstetrics/gynecology Affiliated Physician without a referral from a primary care Affiliated Physician. Also, you may receive care from Plan Providers outside Coachella Valley without a referral from your primary care Affiliated Physician. Some care requires a referral from a primary care Plan Physician, but the Plan Physician does not have to be an Affiliated Physician; for more details, see "Referrals to Plan Providers" in this "How to Obtain Services" section.

We will send you, the Subscriber, a letter explaining how to select a primary care Affiliated Physician. If you don't 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. 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 to Kaiser Permanente Services (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 care, including pediatric care and obstetrics/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. You don't need a referral to receive primary care from Plan Physicians in the following areas: internal medicine, obstetrics/gynecology, family planning, family medicine, pediatrics, optometry, psychiatry, and chemical dependency. Please check *Your Guidebook* to see if your facility has other departments that don't 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 and are 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. Medical Group's criteria for determining whether bariatric surgery is Medical Necessary is described in Medical Group's bariatric surgery referral guidelines, which are available upon request
- **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. If the DME request still doesn't appear to meet our DME formulary guidelines, it 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 for Home Use" in either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage
- **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. If the request still doesn't appear to meet our soft goods formulary guidelines, it 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 either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage

- **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 the 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 either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage.

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. The policies and procedures (including a description of the authorization procedure or information about the authorization procedure applicable to some Plan Providers other than Kaiser Foundation Hospitals and Medical Group) are available upon request from our Member Service Call Center. 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.

Second Opinions

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

Some examples of when a second opinion is Medically Necessary are:

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

The Copayments and Coinsurance for these referral Services are the same as those required for Services provided by a Plan Provider as described in either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage.

Contracts with Plan Providers

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

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 and completion of Services

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements.

In addition, if you are undergoing treatment for specific conditions 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. We may cover these Services 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 be otherwise 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 us. 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 either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage. For more information about this provision, or to make a request, please call our Member Service Call Center.

Visiting other Regions

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

The availability of visiting member care in the visited service area ends after 90 days unless you receive prior written authorization from us to continue receiving covered care in the visited service area. The service areas and facilities where you may obtain visiting member care may change at any time without notice.

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

Your Identification Card

Each Member's Health Plan ID card has a Medical Record Number on it, which you will need when you call for advice, make an appointment, or go to a provider for covered care. 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.

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

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 seven days a week (except holidays), from 7 a.m. to 7 p.m., at 1-800-443-0815 (for the hearing and speech impaired, the TTY line is 1-800-777-1370). For your convenience, you can also contact us through our Web site at *www.kaiserpermanente.org.*

Member Services 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 the "Requests for Payment or Services" section or with any issues as described 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 Service Area. Additional Plan Medical Offices are listed in *Your Guidebook* and on our Web site at *www.kaiserpermanente.org.* This list is subject to change at any time without notice. If there is a change to this list of Plan Facilities, we will update this list in any *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.

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 at many locations
- 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 Facilities

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 Additional Plan Medical Offices: 1001 Riverside Avenue

City	Street address
Sacramento	Medical Centers: 2025 Morse Avenue 6600 Bruceville Road Additional Plan Medical Offices: 1650 Response Road 2345 Fair Oaks Boulevard
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 Additional Plan Medical Offices: 1540 5th Avenue
Santa Clara	Medical Center: 900 Kiely Boulevard
Santa Rosa	Medical Center: 401 Bicentennial Way Additional Plan Medical Offices: 3925 Old Redwood Highway
South San Francisco	Medical Center: 1200 El Camino Real
Stockton	Plan Hospital: 525 West Acacia Street (Dameron Hospital) Plan Medical Office: 7373 West Lane
Turlock	Plan Hospital: 825 Delbon Avenue (Emanuel Medical Center)
Vallejo	Medical Center: 975 Sereno Drive
Walnut Creek	Medical Center: 1425 South Main Street Additional Plan Medical Offices: 320 Lennon Lane Emergency Care is also available at Mount Diablo Medical Center: at 2540 East Street, Concord, which is a Plan Hospital only for Emergency Care

Plan Medical Offices in other cities in the Northern California Region

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
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 Please refer to *Your Guidebook* for other Plan Providers in Stanislaus County
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

City	Street address
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

Southern California Region Facilities

City	Street address
Anaheim	Medical Centers: 441 North Lakeview Avenue 3033 West Orange Avenue (west Anaheim) Additional Plan Medical Offices: 411 North Lakeview Avenue 1188 North Euclid Street
Bakersfield	Plan Hospitals: 420 34th Street (Memorial Hospital) 2215 Truxtun Avenue (Mercy Hospital) 300 Old River Road (Mercy Southwest Hospital) Plan Medical Offices: 1200 Discovery Drive 3501 Stockdale Highway 3700 Mall View Road 8800 Ming Avenue
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 Hospitals: 1600 West Avenue J (Antelope Valley Hospital) 43830 North 10th Street West (Lancaster Community Hospital) Plan Medical Office: 43112 North 15th Street West
Los Angeles	Medical Centers: 1526 North Edgemont Street 6041 Cadillac Avenue (West Los Angeles) Additional Plan Medical Offices: 5119 East Pomona Boulevard 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: 3250 Fordham Street 4405 Vandever Avenue 4650 Palm Avenue 7060 Clairemont Mesa Boulevard 11939 Rancho Bernardo Road
Woodland Hills	Medical Center: 5601 De Soto Avenue

Plan Medical Offices in other cities in the Southern California Region

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	250 Travelodge Drive 1630 East Main Street
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 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
Palmdale	4502 East Avenue S
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 145 Hodencamp Road
Torrance	20790 Madrona Avenue
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
- Eisenhower Medical Center at 39000 Bob Hope Drive, Rancho Mirage
- Hi-Desert Medical Center at 6601 White Feather Road, Joshua Tree
- John F. Kennedy Memorial Hospital at 47111 Monroe Street, Indio

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

Your Guidebook

Plan Medical Offices and Plan Hospitals for your area are listed in greater detail in *Your Guidebook to Kaiser Permanente Services*

(Your Guidebook). Your Guidebook describes the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services. It includes additional facilities that are not listed in this "Plan Facilities" section. Also, it explains how to use our Services and make appointments, and includes a detailed telephone directory for appointments and advice. *Your Guidebook* provides other important information, such as preventive care guidelines and your Member rights and responsibilities. *Your Guidebook* is subject to change and periodically updated. We mail it annually and you can get a copy by calling our Member Service Call Center or by visiting our Web site, *www.kaiserpermanente.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, Post-stabilization Care, urgent 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 either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage (subject to the "Exclusions, Limitations, and Reductions" section).

Emergency, Post-stabilization, and Urgent Care

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
  - 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.

Post-stabilization Care. Post-stabilization Care is the Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable.

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
- In the rare circumstance that we are unavailable or cannot be contacted

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

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

To request authorization to receive Post-stabilization Care from a Non-Plan Provider, the Non-Plan Provider must call us at 1-800-225-8883 *before* you receive the care. 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 Hospital, licensed skilled nursing facility, or designated Non-Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered.

Be sure to ask the Non-Plan Provider to tell you what care (including any transportation) we have authorized since we do not cover unauthorized Post-stabilization Care or related transportation 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.

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 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 the Services could not be delayed until you returned to our Service Area.

Call us!

We encourage you to call us 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. In these cases, please call us as soon as reasonably possible. Please keep in mind that anyone can call us for you.

Follow-up care

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

Payment and reimbursement

If you receive Emergency Care, Post-stabilization Care, or Out-of-Area Urgent 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, Post-stabilization 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 either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage.

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 go to *www.kaiserpermanente.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 answer questions about 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, Copayments, and Coinsurance for Senior Advantage

The Services described in this "Benefits, Copayments, and Coinsurance for Senior Advantage" 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:
  - Emergency Care, Post-stabilization Care, and Out-of-Area Urgent Care, in the "Emergency, Urgent, and Routine Care" section
  - emergency ambulance Services described under "Ambulance Services," in this "Benefits, Copayments, and Coinsurance for Senior Advantage" section
  - out-of-area dialysis care described under "Dialysis Care" in this "Benefits, Copayments, and Coinsurance for Senior Advantage" 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
  - visiting other Regions, in the "How to Obtain Services" section
  - Emergency Care, Post-stabilization Care, and Out-of-Area Urgent Care, in the "Emergency, Urgent, and Routine Care" section
  - emergency ambulance Services described under "Ambulance Services," in this "Benefits, Copayments, and Coinsurance for Senior Advantage" section
  - out-of-area dialysis care described under "Dialysis Care" in this "Benefits, Copayments, and Coinsurance for Senior Advantage" section

Exclusions and limitations that apply only to a particular benefit are described in this "Benefits, Copayments, and Coinsurance for Senior Advantage" 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 covered Emergency Care, Post-stabilization Care, urgent care, and routine care
- *Your Guidebook* for the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service is described in this "Benefits, Copayments, and Coinsurance for Senior Advantage" section. Copayments or Coinsurance are due when you receive the Service. For items ordered in advance, you pay the Copayment or Coinsurance in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it).

Note: If we bill you for a Copayment, we will add **$13.50** to the Copayment and send 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).

The Copayments and Coinsurance you pay for the following Services apply toward the annual out-of-pocket maximum:

- Ambulance Services
- Emergency Department and Out-of-Area Urgent Care visits
- Home health care
- Hospice care
- Hospital care, including mental health inpatient care
- Imaging, laboratory, and special procedures
- Office visits (including professional Services such as dialysis treatment, health education, and physical, occupational, and speech therapy)
- Outpatient surgery
- Skilled Nursing Facility care

Keeping track of the maximum

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 to find out where to turn in your receipts. When you turn them in, we will give you a document stating that you don't have to pay any more Copayments or Coinsurance for these Services through the end of the calendar year.

Changes to national coverage rules

The Medicare program can change its national coverage rules at any time. These changes could affect your benefits. In some cases, if your benefits increase, Original Medicare will pay for the benefit for a limited time. In those cases, you may have to pay Original Medicare Coinsurance for the Services. Once the Services become part of your regular Senior Advantage benefits (usually at the beginning of the next calendar year), the Services will be subject to all applicable Senior Advantage Copayments and Coinsurance rather than Original Medicare coinsurance.

Special Note about Clinical Trials

Original Medicare will pay for certain Services related to qualifying clinical trials that we do not cover. 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 at 1-800-MEDICARE (1-800-633-4227) (*TTY 1-877-486-2048*) 24 hours a day, seven days a week.

Outpatient Care

We cover the following outpatient care for preventive medicine, diagnosis, and treatment upon payment of the Copayment or Coinsurance indicated:

- Primary and specialty care visits for internal medicine, gynecology, family medicine, and pediatrics: **$10 per visit**, except for the following:
  - Well-child preventive care visits (23 months or younger): **no charge**
  - After confirmation of pregnancy, all scheduled Obstetrical Department prenatal visits and the first postpartum visit: **no charge**
  - Allergy injection visits: **$3 per visit**
- Routine preventive physical exams: **$10 per visit**
- Family planning visits for counseling, or to obtain an emergency contraceptive pill,

internally implanted time-release contraceptive, or intrauterine device (IUD): **$10 per visit**

- Outpatient surgery, anesthesia, and other outpatient procedures: **$10 per procedure**
- Voluntary termination of pregnancy: **$10 per procedure**
- Manual manipulation of the spine is provided at **$10 per visit** to correct subluxation, as covered by Medicare, but only if the manipulation is performed for Southern California Region Members by an American Specialty Health Plans of California, Inc. (ASH Plans), participating chiropractor (no referral required), or by a Plan osteopath or chiropractor for Northern California Region Members. For the list of participating ASH Plans providers, please refer to your ASH Plans provider directory. To request an ASH Plans provider directory, please call our Member Service Call Center
- Emergency Department and Out-of-Area Urgent Care visits: **$50 per visit**. The Copayment is waived if you are admitted directly to the hospital as an inpatient within 24 hours for the same condition. Please refer to the "Emergency, Urgent, and Routine Care" section for information about Emergency Care and urgent care
- House calls inside our Service Area when care can best be provided in your home as determined by a Plan Physician: **no charge**
- Blood, blood products, and their administration: **no charge**
- Administered drugs: If administration or observation by medical personnel is required, we cover at **no charge** drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials if they are administered to you in a Plan Medical Office or during home visits
- Immunizations and vaccines approved for use by the federal Food and Drug Administration (FDA) and administered to you in a Plan Medical Office: **no charge**
- Preventive health screenings, such as screening and tests for colorectal cancer in accord with Medicare guidelines: **$10 per procedure**
- Some types of outpatient visits may be available as group appointments, which are covered at **$5 per visit**.

The following types of outpatient Services are covered only as described under these headings in this "Benefits, Copayments, and Coinsurance for Senior Advantage" section:

- Chemical Dependency Services
- Dental Services for Radiation Treatment and Dental Anesthesia
- Dialysis Care
- Durable Medical Equipment for Home Use
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Infertility Services
- Mental Health Services
- Ostomy and Urological Supplies
- Outpatient Imaging, Laboratory, and Special Procedures
- Outpatient Prescription Drugs, Supplies, and Supplements
- Physical, Occupational, and Speech Therapy, and Multidisciplinary Rehabilitation Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Transplant Services
- Vision Services

Special note about colon cancer screening

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.

If you get a flexible sigmoidoscopy, you have a choice of having it performed by Plan Providers designated under Original Medicare or Senior Advantage guidelines. Under Original Medicare guidelines, a Plan Physician, Plan Physician assistant, Plan nurse practitioner, or Plan certified nurse specialist may perform the sigmoidoscopy. Under Senior Advantage guidelines, one of these Plan Providers or a Plan registered nurse may perform it. If you are going to get a flexible sigmoidoscopy, please let us know if you have a preference regarding which of these guidelines to use.

Hospital Inpatient Care

We cover the following inpatient Services at **$250 per admission** in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Area:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Plan Physicians' and surgeons' Services, including consultation and treatment by specialists
- Anesthesia
- Drugs and radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and special procedures
- Blood, blood products, and their administration
- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge
- Respiratory therapy
- Medical social services and discharge planning

The following types of inpatient Services are covered only as described under the following headings in this "Benefits, Copayments, and Coinsurance for Senior Advantage" section:

- Chemical Dependency Services
- Dental Services for Radiation Treatment and Dental Anesthesia
- Dialysis Care
- Hospice Care
- Infertility Services
- Mental Health Services
- 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

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
- You are not already being treated, and you reasonably believe that your condition requires ambulance transportation

Nonemergency

Inside our Service Area, we cover nonemergency ambulance Services in accord with Medicare guidelines 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 at **$250 per admission** in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Outpatient

We cover the following Services for treatment of chemical dependency at **$10 per visit** for individual therapy visits and **$5 per visit** for group therapy visits:

- Day treatment programs
- Intensive outpatient programs
- Counseling (both individual and group visits) for chemical dependency
- Medical treatment for withdrawal symptoms
- Methadone maintenance treatment 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 at **$100 per admission** up to 60 days per calendar year of chemical dependency treatment in a nonmedical transitional residential recovery setting approved in writing by Medical Group. We do not cover more than 120 days of covered care in any five consecutive calendar year period. These settings provide counseling and support services in a structured environment.

Chemical dependency Services exclusion

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

Dental Services for Radiation Treatment and Dental Anesthesia

Dental Services for radiation treatment

We cover services covered by Medicare, including evaluation, extraction, dental X-rays, and fluoride treatment at **$10 per visit**, 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 are true:

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

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

For covered dental anesthesia Services, you will pay the Copayments or Coinsurance that you would pay for hospital inpatient care or outpatient surgery, depending on the setting.

Dialysis Care

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

- You satisfy all medical criteria developed by the Medical Group
- The facility is certified by Medicare
- A Plan Physician provides a written referral for your dialysis treatment except for out-of-area dialysis care

We also cover peritoneal home dialysis (including equipment, training, and medical supplies).

Out-of-area dialysis care

We cover dialysis for Members with end-stage renal disease 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 end-stage renal disease 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.

You pay the following for these covered Services:

- Inpatient dialysis care: **$250 per admission**
- Physician office visits: **$10 per visit**
- Dialysis treatment visits: **no charge**

Durable Medical Equipment for Home Use

Durable medical equipment for use in your home 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 in accord with our DME formulary and Medicare guidelines for use in your home (or another location used as your home as defined by Medicare inside our Service Area). Coverage is limited to the standard item of equipment that adequately meets your medical needs. Covered DME is provided at **no charge**.

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.

Outside the Service Area

For Members enrolled in Senior Advantage on December 31, 1998, who lived outside our Service Area and continue to live at the same address, we do not cover most DME for use in your home. However, 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 if you live outside our Service Area, please call our Member Service Call Center.

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. Our 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 item 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: This "Durable Medical Equipment for Home Use" section applies to the following diabetes blood testing supplies and equipment and insulin-administration devices:

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

Other diabetes testing supplies and insulin-administration devices are not covered under this "Durable Medical Equipment for Home Use" section (instead, refer to the "Outpatient Prescription Drugs, Supplies, and Supplements" section).

Durable medical equipment exclusions

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

Health Education

We cover a variety of health education programs to help you take an active role in protecting and improving your health, including programs for smoking cessation, stress management, and chronic conditions (such as diabetes and asthma). We cover individual office visits at **$10 per visit** and all other covered Services at **no charge**. 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, or go to *www.kaiserpermanente.org*. *Your Guidebook* also includes information about our health education programs.

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

We cover the following:

- Hearing tests to determine the need for hearing correction: **$10 per visit**
- Hearing tests to determine the appropriate hearing aid: **no charge**
- A **$2,500 Allowance** for each ear toward the price of a hearing aid every 36 months when prescribed by a Plan Physician or Plan audiologist. We will cover hearing aids for both ears only if both aids are required to provide significant improvement that is not obtainable with only one hearing aid. We will not provide the Allowance if we have covered a hearing aid for that ear within the previous 36 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
- Visits to verify that the hearing aid conforms to the prescription: **no charge**
- Visits for fitting, counseling, adjustment, cleaning, and inspection after the warranty is exhausted: **no charge**

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

- Internally implanted hearing aids
- Replacement parts and batteries, repair of hearing aids, and replacement of lost or broken hearing aids (the manufacturer warranty may cover some of these)

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 care in accord with Medicare guidelines at **no charge** only 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 and that the Services can be safely and effectively provided in your home
- The Services are provided inside our Service Area
- The Services are covered by Medicare, such as part-time or intermittent skilled nursing care and part-time or intermittent Services of a home health aide

The following types of Services are covered in the home only as described under these headings in this "Benefits, Copayments, and Coinsurance for Senior Advantage" section:

- Dialysis Care
- Durable Medical Equipment for Home Use
- Ostomy and Urological Supplies
- Outpatient Prescription Drugs, Supplies, and Supplements
- 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
- Care in the home if the home is not a safe and effective treatment setting

Hospice Care

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

We cover the hospice Services listed below at **no charge** 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
- The Services are provided by a licensed hospice agency approved by Medical Group
- The Services are necessary for the palliation and management of your terminal illness and related conditions

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

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, or speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from Plan Pharmacies. Certain drugs are limited to a maximum 30-day supply in any 30-day period (please call our Member Service Call Center for the current list of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling
- The following care during periods of crisis when you need continuous care to achieve palliation or management of acute medical symptoms:
  - nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
  - short-term inpatient care required at a level that cannot be provided at home

Special note for Members with Medicare Parts A and B

Medicare covers hospice care directly for Members with Medicare Parts A and B. Although we do not cover hospice care, 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.

Note: We do cover hospice consultation services for terminally ill Members with Medicare Parts A and B who have not yet elected the hospice benefit.

Infertility Services

We cover the following infertility 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)

You pay the following for these covered infertility Services:

- Office visits: **$10 per visit**
- Outpatient surgery and other outpatient procedures: **$10 per procedure**
- Outpatient laboratory, imaging, and special procedures: **no charge**
- Hospital inpatient care (including room and board and Plan Physician Services): **$250 per admission**

Note: Diagnostic procedures are not covered under this "Infertility Services" section (instead, refer to the "Outpatient Imaging, Laboratory, and Special Procedures" section). Also, outpatient drugs, supplies, and supplements are not covered under this section (instead, refer to the "Outpatient Prescription Drugs, Supplies, and Supplements" section).

Infertility Services exclusion

- Services to reverse voluntary, surgically induced infertility

Mental Health Services

We cover mental health Services as specified below, except that any inpatient-day limits specified in this section under "Inpatient psychiatric care" 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 age 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 the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
  - the child displays psychotic features, or risk of suicide or violence due to a mental disorder
  - the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

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:

- Individual and group therapy visits for diagnostic evaluation and psychiatric treatment
- Psychological testing
- Visits for the purpose of monitoring drug therapy

You pay the following for these covered Services:

- Individual therapy 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 at **$250 per admission**. 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.

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: Outpatient drugs, supplies, and supplements are not covered under this "Mental Health Services" section (instead, refer to the "Outpatient Prescription Drugs, Supplies, and Supplements" section).

Ostomy and Urological Supplies

Inside our Service Area, we cover ostomy and urological supplies prescribed in accord with our soft goods formulary and Medicare guidelines at **no charge**. 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. Our 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 they are Medically Necessary as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

Ostomy and urological supplies exclusion

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Special Procedures

We cover the following Services at the Copayment or Coinsurance indicated only when prescribed as part of care covered under

other parts of this "Benefits, Copayments, and Coinsurance for Senior Advantage" 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, mammograms, and ultrasound: **no charge** except certain imaging procedures: **$10 per procedure** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room; or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort
- Magnetic resonance imaging (MRI), computerized tomography (CT), and positron emission tomography (PET): **no charge**
- Nuclear medicine: **no charge**
- Laboratory tests (including screening tests for diabetes, cardiovascular disease, and cervical cancer and tests for specific genetic disorders for which genetic counseling is available): **no charge**
- Special procedures: **$10 per procedure** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room; or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. Any other special procedures (such as electrocardiograms and electroencephalograms): **no charge**
- Radiation therapy: **no charge**
- Ultraviolet light treatments: **no charge**
- Annual mammograms for women age 40 and over (no referral required): **no charge**

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section and drugs covered by Medicare in accord with our drug formulary guidelines and when prescribed by a Plan Physician (except as otherwise described under "Outpatient drugs, supplies, and supplements"). You must obtain covered drugs, supplies, and supplements from a Plan Pharmacy. Please refer to *Your Guidebook* for the locations of Plan Pharmacies in your area.

You may be able to order refills through our Web site at *www.kaiserpermanente.org.* A Plan Pharmacy or *Your Guidebook* can give you more information about obtaining refills (for example, a few Plan Pharmacies don't dispense covered refills). Also, most refills are available through our mail-order program. Plan Pharmacies can give you details, including whether you can use the mail-order program to refill your prescription. Items available through our mail-order program are subject to change at any time without notice.

Outpatient drugs, supplies, and supplements

We cover the following outpatient drugs, supplies, and supplements when prescribed by a Plan Physician or by a dentist (drugs, supplies, and supplements prescribed by dentists are not covered if a Plan Physician determines that they are not Medically Necessary):

- 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. Note: Smoking-cessation drugs are covered only if you participate in a Plan-approved behavioral intervention program

- Diaphragms, cervical caps, and oral contraceptives (including emergency contraceptive pills)
- Disposable needles and syringes needed for injecting covered drugs

Copayments and Coinsurance for outpatient drugs, supplies, and supplements. The Copayments and Coinsurance for these outpatient items are:

- Generic items: **$10** for up to a 100-day supply
- Generic drugs related to the treatment of sexual dysfunction disorders: **50% Coinsurance** for up to a 100-day supply. Note: Episodic drugs are provided up to a maximum of 27 doses in any 100-day period
- Brand-name items or compounded products: **$20** for up to a 100-day supply
- Brand-name drugs related to the treatment of sexual dysfunction disorders: **50% Coinsurance** for up to a 100-day supply. Note: Episodic drugs are provided up to a maximum of 27 doses in any 100-day period
- 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** for up to a 30-day supply
- Emergency contraceptive pills: **no charge**
- Continuity drugs: 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 **50% Coinsurance** for up to a 30-day supply in a 30-day period (episodic sexual dysfunction drugs are provided for up to 8 doses in any 30-day period)

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

Certain IV drugs, supplies, and supplements

We cover certain self-administered IV drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as an IV or intraspinal-infusion) at **no charge** for up to a 30-day supply. We also cover the supplies and equipment required for their administration at **no charge**. Note: 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).

Diabetes urine-testing supplies and insulin-administration devices

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

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

Note: Diabetes blood-testing equipment (and their supplies) and insulin pumps (and their supplies) are not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section (instead, refer to the "Durable Medical Equipment for Home Use" section).

Day supply limit

Plan Physicians determine the amount of a drug, supply, or supplement that equals a Medically Necessary 30-day supply (or 100-day supply) for you. Upon payment of the Copayment or Coinsurance listed in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, you will receive the supply prescribed up to the day supply limit

also specified in this section. The day supply limit is either a 30-day supply in a 30-day period or a 100-day supply in a 100-day period. If you wish to receive more than the day supply limit, then you must pay Charges for any prescribed quantities that exceed the day supply limit.

The pharmacy may reduce the day supply dispensed if the pharmacy determines that the item is in limited supply in the market. Also, the pharmacy may reduce the day supply dispensed at the Copayment or Coinsurance 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).

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 to request a copy of our drug formulary, please call our Member Service Call Center. The presence of a drug on our drug formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition.

Our drug formulary guidelines allow you to obtain nonformulary prescription drugs (those not listed on our drug formulary for your condition) if 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 an appeal 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.

Note: Durable medical equipment used to administer drugs is not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section (instead, refer to the "Durable Medical Equipment for Home Use" section).

Outpatient prescription drugs, supplies, and supplements exclusions

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

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

You pay the following for these covered Services:

- 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.

You pay the following for these covered Services:

- Inpatient: **$250 per admission**
- Outpatient: **$10 per day**

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, devices are limited to the standard device that adequately meets your medical needs.

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
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- 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
  - Special footwear for foot disfigurement due to disease, injury, or developmental disability

Prosthetic and orthotic devices exclusions

- Eyeglasses and contact lenses under this benefit (see the "Vision Services" section)
- Hearing aids under this benefit (see the "Hearing Services" 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
- 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.

Also, following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas.

You pay the following for covered reconstructive surgery Services:

- Office visits: **$10 per visit**
- Outpatient surgery and other outpatient procedures: **$10 per procedure**
- Hospital inpatient care (including room and board and Plan Physician Services): **$250 per admission**

Note: Prosthetics and orthotics are not covered under this "Reconstructive Surgery" section (instead, refer to the "Prosthetic and Orthotic Devices" section).

Reconstructive surgery exclusions

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

Religious Nonmedical Health Care Institution Services

Certain Services in a Medicare-certified Religious Nonmedical Health Care Institution (RNHCI) are covered at the Copayments and Coinsurance you would pay if the Services were not related to an RNHCI. However, religious aspects of care provided in a RNHCI are not covered. If you want to receive care in an RNHCI, please call our Member Service Call Center to learn about the requirements you must satisfy.

Skilled Nursing Facility Care

Inside our Service Area, we cover at **no charge** up to 100 days per benefit period of skilled inpatient Services in a licensed Skilled Nursing Facility and in accord with Medicare guidelines. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

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

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by Plan Physicians in accord with our drug formulary
- Durable medical equipment in accord with our DME formulary if Skilled Nursing Facilities ordinarily furnish the equipment
- Imaging, laboratory, and special procedures
- Medical social services
- Blood, blood products, and their administration
- Medical supplies
- Services covered under "Physical, Occupational, and Speech Therapy, and Multidisciplinary Rehabilitation Services"
- Respiratory therapy

Designating a Skilled Nursing Facility

Upon discharge from a Plan Hospital, we will cover Skilled Nursing Facility care at the following Skilled Nursing Facilities inside our Service Area, if we have an agreement with the Skilled Nursing Facility to provide you 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
- The Skilled Nursing Facility where your Spouse is residing at the time you are discharged from the hospital

Transplant Services

We cover transplants of organs, tissue, or bone marrow in accord with Medicare guidelines and 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
- 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 is available by calling our Member Service Call Center

For these covered Services, you will pay the Copayments and Coinsurance you would pay if the Services were not related to a transplant.

Vision Services

We cover the Services listed below at Plan Medical Offices or Plan optical sales offices when prescribed by a Plan Physician or Plan optometrist.

Eye exams

Glaucoma screenings in accord with Medicare guidelines and refraction exams to determine the need for vision correction and to provide a prescription for eyeglass lenses are covered at **$10 per visit**.

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 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 when prescribed by a Plan Physician or Plan optometrist:

- We will provide at **no charge** up to two contact lenses per eye every 12 months to treat aniridia (missing iris)
- We will provide at **no charge** up to five aphakic contact replacement lenses per eye under this or any other *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 under "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. The Allowance is to help you pay for eyeglass lenses, frames, and contact lenses (including fitting and dispensing). 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 Allowance of $150 following any cataract surgery.

Vision Services exclusions

- Services related to eye surgery or orthokeratologic Services for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism
- Industrial frames
- Lenses and sunglasses without refractive value except for:
  - A balance lens if only one eye needs correction
  - 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

Benefits, Copayments, and Coinsurance for Senior Advantage MSP

The Services described in this "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" 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:
  - Emergency Care, Post-stabilization Care, and Out-of-Area Urgent Care, in the "Emergency, Urgent, and Routine Care" section
  - emergency ambulance Services described under "Ambulance Services," in this "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section
  - out-of-area dialysis care described under "Dialysis Care" in this "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" 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
  - visiting other Regions, in the "How to Obtain Services" section
  - Emergency Care, Post-stabilization Care, and Out-of-Area Urgent Care, in the "Emergency, Urgent, and Routine Care" section
  - emergency ambulance Services described under "Ambulance Services," in this "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section
  - out-of-area dialysis care described under "Dialysis Care" in this "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section

Exclusions and limitations that apply only to a particular benefit are described in this "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" 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 covered Emergency Care, Post-stabilization Care, urgent care, and routine care
- *Your Guidebook* for the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service is described in this "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section. Copayments or Coinsurance are due when you receive the Service. For items ordered in advance, you pay the Copayment or Coinsurance in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it).

Note: If we bill you for a Copayment, we will add **$13.50** to the Copayment and send 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).

The Copayments and Coinsurance you pay for the following Services apply toward the annual out-of-pocket maximum:

- Ambulance Services
- Emergency Department and Out-of-Area Urgent Care visits
- Home health care
- Hospice care
- Hospital care, including mental health inpatient care
- Imaging, laboratory, and special procedures
- Office visits (including professional Services such as dialysis treatment, health education, and physical, occupational, and speech therapy)
- Outpatient surgery
- Skilled Nursing Facility care

Keeping track of the maximum

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 to find out where to turn in your receipts. When you turn them in, we will give you a document stating that you don't have to pay any more Copayments or Coinsurance for these Services through the end of the calendar year.

Changes to national coverage rules

The Medicare program can change its national coverage rules at any time. These changes could affect your benefits. In some cases, if your benefits increase, Original Medicare will pay for the benefit for a limited time. In those cases, you may have to pay Original Medicare Coinsurance for the Services. Once the Services become part of your regular Senior Advantage benefits (usually at the beginning of the next calendar year), the Services will be subject to all applicable Senior Advantage Copayments and Coinsurance rather than Original Medicare coinsurance.

Special Note about Clinical Trials

Original Medicare will pay for certain Services related to qualifying clinical trials that we do not cover. 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 at 1-800-MEDICARE (1-800-633-4227) (*TTY 1-877-486-2048*) 24 hours a day, seven days a week.

Outpatient Care

We cover the following outpatient care for preventive medicine, diagnosis, and treatment upon payment of the Copayment or Coinsurance indicated:

- Primary and specialty care visits for internal medicine, gynecology, family medicine, and pediatrics: **no charge**
- Routine preventive physical exams: **no charge**
- Family planning visits for counseling, or to obtain an emergency contraceptive pill, internally implanted time-release contraceptive, or intrauterine device (IUD): **no charge**
- Outpatient surgery, anesthesia, and other outpatient procedures: **no charge**
- Voluntary termination of pregnancy: **no charge**

- Manual manipulation of the spine is provided at **no charge** to correct subluxation, as covered by Medicare, but only if the manipulation is performed for Southern California Region Members by an American Specialty Health Plans of California, Inc. (ASH Plans), participating chiropractor (no referral rquired), or by a Plan osteopath or chiropractor for Northern California Region Members. For the list of participating ASH Plans providers, please refer to your ASH Plans provider directory. To request an ASH Plans provider directory, please call our Member Service Call Center
- Emergency Department and Out-of-Area Urgent Care visits: **no charge**. Please refer to the "Emergency, Urgent, and Routine Care" section for information about Emergency Care and urgent care
- House calls inside our Service Area when care can best be provided in your home as determined by a Plan Physician: **no charge**
- Blood, blood products, and their administration: **no charge**
- Administered drugs: If administration or observation by medical personnel is required, we cover at **no charge** drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials if they are administered to you in a Plan Medical Office or during home visits
- Immunizations and vaccines approved for use by the federal Food and Drug Administration (FDA) and administered to you in a Plan Medical Office: **no charge**
- Preventive health screenings, such as screening and tests for colorectal cancer in accord with Medicare guidelines: **no charge**

The following types of outpatient Services are covered only as described under these headings in this "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section:

- Chemical Dependency Services
- Dental Services for Radiation Treatment and Dental Anesthesia
- Dialysis Care
- Durable Medical Equipment for Home Use
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Infertility Services
- Mental Health Services
- Ostomy and Urological Supplies
- Outpatient Imaging, Laboratory, and Special Procedures
- Outpatient Prescription Drugs, Supplies, and Supplements
- Physical, Occupational, and Speech Therapy, and Multidisciplinary Rehabilitation Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Transplant Services
- Vision Services

Special note about colon cancer screening

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.

If you get a flexible sigmoidoscopy, you have a choice of having it performed by Plan Providers designated under Original Medicare or Senior Advantage guidelines. Under Original Medicare guidelines, a Plan Physician, Plan Physician assistant, Plan nurse practitioner, or Plan certified nurse specialist may perform the sigmoidoscopy. Under Senior

Advantage guidelines, one of these Plan Providers or a Plan registered nurse may perform it. If you are going to get a flexible sigmoidoscopy, please let us know if you have a preference regarding which of these guidelines to use.

Hospital Inpatient Care

We cover the following inpatient Services at **no charge** in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Area:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Plan Physicians' and surgeons' Services, including consultation and treatment by specialists
- Anesthesia
- Drugs and radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and special procedures
- Blood, blood products, and their administration
- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge
- Respiratory therapy
- Medical social services and discharge planning

The following types of inpatient Services are covered only as described under the following headings in this "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section:

- Chemical Dependency Services
- Dental Services for Radiation Treatment and Dental Anesthesia
- Dialysis Care
- Hospice Care
- Infertility Services
- Mental Health Services
- 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

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
- You are not already being treated, and you reasonably believe that your condition requires ambulance transportation

Nonemergency

Inside our Service Area, we cover nonemergency ambulance Services in accord with Medicare guidelines 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 at **no charge** in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Outpatient

We cover the following Services for treatment of chemical dependency at **no charge** for individual therapy visits and **no charge** for group therapy visits:

- Day treatment programs
- Intensive outpatient programs
- Counseling (both individual and group visits) for chemical dependency
- Medical treatment for withdrawal symptoms
- Methadone maintenance treatment 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 at **no charge** up to 60 days per calendar year of chemical dependency treatment in a nonmedical transitional residential recovery setting approved in writing by Medical Group. We do not cover more than 120 days of covered care in any five consecutive calendar year period. These settings provide counseling and support services in a structured environment.

Chemical dependency Services exclusion

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

Dental Services for Radiation Treatment and Dental Anesthesia

Dental Services for radiation treatment

We cover services covered by Medicare, including evaluation, extraction, dental X-rays, and fluoride treatment at **no charge**, 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 are true:

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

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

For covered dental anesthesia Services, you will pay the Copayments or Coinsurance that you would pay for hospital inpatient care or outpatient surgery, depending on the setting.

Dialysis Care

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

- You satisfy all medical criteria developed by the Medical Group
- The facility is certified by Medicare
- A Plan Physician provides a written referral for your dialysis treatment except for out-of-area dialysis care

We also cover peritoneal home dialysis (including equipment, training, and medical supplies).

Out-of-area dialysis care

We cover dialysis for Members with end-stage renal disease 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 end-stage renal disease 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.

You pay the following for these covered Services:

- Inpatient dialysis care: **no charge**
- Physician office visits: **no charge**
- Dialysis treatment visits: **no charge**

Durable Medical Equipment for Home Use

Durable medical equipment for use in your home 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 in accord with our DME formulary and Medicare guidelines for use in your home (or another location used as your home as defined by Medicare inside our Service Area). Coverage is limited to the standard item of equipment that adequately meets your medical needs. Covered DME is provided at **no charge**.

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.

Outside the Service Area

For Members enrolled in Senior Advantage on December 31, 1998, who lived outside our Service Area and continue to live at the same address, we do not cover most DME for use in your home. However, 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 if you live outside our Service Area, please call our Member Service Call Center.

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. Our 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 item 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: This "Durable Medical Equipment for Home Use" section applies to the following diabetes blood testing supplies and equipment and insulin-administration devices:

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

Other diabetes testing supplies and insulin-administration devices are not covered under this "Durable Medical Equipment for Home Use" section (instead, refer to the "Outpatient Prescription Drugs, Supplies, and Supplements" section).

Durable medical equipment exclusions

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

Health Education

We cover a variety of health education programs to help you take an active role in protecting and improving your health, including programs for smoking cessation, stress management, and chronic conditions (such as diabetes and asthma). We cover individual office visits at **no charge** and all other covered Services at **no charge**. 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, or go to *www.kaiserpermanente.org*. *Your Guidebook* also includes information about our health education programs.

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

We cover the following:

- Hearing tests to determine the need for hearing correction: **no charge**
- Hearing tests to determine the appropriate hearing aid: **no charge**

- A **$2,500 Allowance** for each ear toward the price of a hearing aid every 36 months when prescribed by a Plan Physician or Plan audiologist. We will cover hearing aids for both ears only if both aids are required to provide significant improvement that is not obtainable with only one hearing aid. We will not provide the Allowance if we have covered a hearing aid for that ear within the previous 36 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
- Visits to verify that the hearing aid conforms to the prescription: **no charge**
- Visits for fitting, counseling, adjustment, cleaning, and inspection after the warranty is exhausted: **no charge**

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

- Internally implanted hearing aids
- Replacement parts and batteries, repair of hearing aids, and replacement of lost or broken hearing aids (the manufacturer warranty may cover some of these)

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 care in accord with Medicare guidelines at **no charge** only 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 and that the Services can be safely and effectively provided in your home
- The Services are provided inside our Service Area
- The Services are covered by Medicare, such as part-time or intermittent skilled nursing care and part-time or intermittent Services of a home health aide

The following types of Services are covered in the home only as described under these headings in this "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section:

- Dialysis Care
- Durable Medical Equipment for Home Use
- Ostomy and Urological Supplies
- Outpatient Prescription Drugs, Supplies, and Supplements
- 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
- Care in the home if the home is not a safe and effective treatment setting

Hospice Care

Hospice care is a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts of a Member experiencing the last phases of life due to a terminal illness. It also provides support to the primary caregiver and the Member's family. A Member who chooses

hospice care is choosing to receive palliative care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice care benefits at any time.

We cover the hospice Services listed below at **no charge** 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
- The Services are provided by a licensed hospice agency approved by Medical Group
- The Services are necessary for the palliation and management of your terminal illness and related conditions

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

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, or speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from Plan Pharmacies. Certain drugs are limited to a maximum 30-day supply in any 30-day period (please call our Member Service Call Center for the current list of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling
- The following care during periods of crisis when you need continuous care to achieve palliation or management of acute medical symptoms:
  - nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
  - short-term inpatient care required at a level that cannot be provided at home

Special note for Members with Medicare Parts A and B

Medicare covers hospice care directly for Members with Medicare Parts A and B. Although we do not cover hospice care, 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.

Note: We do cover hospice consultation services for terminally ill Members with Medicare Parts A and B who have not yet elected the hospice benefit.

Infertility Services

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

- 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 the "Outpatient Imaging, Laboratory, and Special Procedures" section). Also, outpatient drugs, supplies, and supplements are not covered under this section (instead, refer to the "Outpatient Prescription Drugs, Supplies, and Supplements" section).

Infertility Services exclusion

- Services to reverse voluntary, surgically induced infertility

Mental Health Services

We cover mental health Services as specified below, except that any inpatient-day limits specified in this section under "Inpatient psychiatric care" 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 age 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 the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
  - the child displays psychotic features, or risk of suicide or violence due to a mental disorder
  - the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

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 at **no charge**:

- Individual and group therapy visits for diagnostic evaluation and psychiatric treatment
- Psychological testing
- Visits for the purpose of monitoring drug therapy

Inpatient psychiatric care

We cover up to 190 days per lifetime for acute psychiatric conditions in a Medicare-certified psychiatric hospital at **no charge**. 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.

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: Outpatient drugs, supplies, and supplements are not covered under this "Mental Health Services" section (instead, refer to the "Outpatient Prescription Drugs, Supplies, and Supplements" section).

Ostomy and Urological Supplies

Inside our Service Area, we cover ostomy and urological supplies prescribed in accord with our soft goods formulary and Medicare guidelines at **no charge**. 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. Our 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 they are Medically Necessary as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

Ostomy and urological supplies exclusion

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Special Procedures

We cover the following Services at the Copayment or Coinsurance indicated only when prescribed as part of care covered under other parts of this "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" 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, mammograms, and ultrasound: **no charge**
- Magnetic resonance imaging (MRI), computerized tomography (CT), and positron emission tomography (PET): **no charge**
- Nuclear medicine: **no charge**
- Laboratory tests (including screening tests for diabetes, cardiovascular disease, and cervical cancer and tests for specific genetic disorders for which genetic counseling is available): **no charge**
- Special procedures: **no charge**
- Radiation therapy: **no charge**

- Ultraviolet light treatments: **no charge**
- Annual mammograms for women age 40 and over (no referral required): **no charge**

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section and drugs covered by Medicare in accord with our drug formulary guidelines and when prescribed by a Plan Physician (except as otherwise described under "Outpatient drugs, supplies, and supplements"). You must obtain covered drugs, supplies, and supplements from a Plan Pharmacy. Please refer to *Your Guidebook* for the locations of Plan Pharmacies in your area.

You may be able to order refills through our Web site at *www.kaiserpermanente.org.* A Plan Pharmacy or *Your Guidebook* can give you more information about obtaining refills (for example, a few Plan Pharmacies don't dispense covered refills). Also, most refills are available through our mail-order program. Plan Pharmacies can give you details, including whether you can use the mail-order program to refill your prescription. Items available through our mail-order program are subject to change at any time without notice.

Outpatient drugs, supplies, and supplements

We cover the following outpatient drugs, supplies, and supplements when prescribed by a Plan Physician or by a dentist (drugs, supplies, and supplements prescribed by dentists are not covered if a Plan Physician determines that they are not Medically Necessary):

- 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. Note: Smoking-cessation drugs are covered only if you participate in a Plan-approved behavioral intervention program
- Diaphragms, cervical caps, and oral contraceptives (including emergency contraceptive pills)
- Disposable needles and syringes needed for injecting covered drugs

Copayments and Coinsurance for outpatient drugs, supplies, and supplements. The Copayment for these outpatient items is **no charge** for up to a 100-day supply, except that the following items require payment of a different Copayment or Coinsurance:

- Drugs related to the treatment of sexual dysfunction disorders: **no charge** for up to a 100-day supply. Note: Episodic drugs are provided up to a maximum of 27 doses in any 100-day period
- 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** for up to a 30-day supply
- Emergency contraceptive pills: **no charge**
- Continuity drugs: 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 **50% Coinsurance** for up to a 30-day supply in a 30-day period (episodic sexual dysfunction drugs are provided for up to 8 doses in any 30-day period)

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

Certain IV drugs, supplies, and supplements

We cover certain self-administered IV drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as an IV or intraspinal-infusion) at **no charge** for up to a 30-day supply. We also cover the supplies and equipment required for their administration at **no charge**. Note: 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).

Diabetes urine-testing supplies and insulin-administration devices

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

We cover the following insulin-administration devices at **no charge** for up to a 100-day supply: disposable needles and syringes, pen delivery devices, and visual aids required to ensure proper dosage (except eyewear).

Note: Diabetes blood-testing equipment (and their supplies) and insulin pumps (and their supplies) are not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section (instead, refer to the "Durable Medical Equipment for Home Use" section).

Day supply limit

Plan Physicians determine the amount of a drug, supply, or supplement that equals a Medically Necessary 30-day supply (or 100-day supply) for you. Upon payment of the Copayment or Coinsurance listed in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, you will receive the supply prescribed up to the day supply limit also specified in this section. The day supply limit is either a 30-day supply in a 30-day period or a 100-day supply in a 100-day period.

If you wish to receive more than the day supply limit, then you must pay Charges for any prescribed quantities that exceed the day supply limit.

The pharmacy may reduce the day supply dispensed if the pharmacy determines that the item is in limited supply in the market. Also, the pharmacy may reduce the day supply dispensed at the Copayment or Coinsurance 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).

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 to request a copy of our drug formulary, please call our Member Service Call Center. The presence of a drug on our drug formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition.

Our drug formulary guidelines allow you to obtain nonformulary prescription drugs (those not listed on our drug formulary for your condition) if 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 an appeal 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.

Note: Durable medical equipment used to administer drugs is not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section (instead, refer to the "Durable Medical Equipment for Home Use" section).

Outpatient prescription drugs, supplies, and supplements exclusions

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

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

You pay the following for these covered Services:

- Inpatient Services: **no charge**
- Outpatient visits: **no charge**

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.

You pay the following for these covered Services:

- Inpatient: **no charge**
- Outpatient: **no charge**

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, devices are limited to the standard device that adequately meets your medical needs.

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
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- 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
  - Special footwear for foot disfigurement due to disease, injury, or developmental disability is covered for Southern California Members. Senior Advantage MSP Members enrolled in the Kaiser Permanente Northern California Region are not covered for special footwear

Prosthetic and orthotic devices exclusions

- Eyeglasses and contact lenses under this benefit (see the "Vision Services" section)
- Hearing aids under this benefit (see the "Hearing Services" 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
- 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.

Also, following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas.

You pay the following for covered reconstructive surgery Services:

- Office visits: **no charge**
- Outpatient surgery and other outpatient procedures: **no charge**
- Hospital inpatient care (including room and board and Plan Physician Services): **no charge**

Note: Prosthetics and orthotics are not covered under this "Reconstructive Surgery" section (instead, refer to the "Prosthetic and Orthotic Devices" section).

Reconstructive surgery exclusions

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

Religious Nonmedical Health Care Institution Services

Certain Services in a Medicare-certified Religious Nonmedical Health Care Institution (RNHCI) are covered at the Copayments and Coinsurance you would pay if the Services were not related to an RNHCI. However, religious aspects of care provided in a RNHCI are not covered. If you want to receive care in an RNHCI, please call our Member Service Call Center to learn about the requirements you must satisfy.

Skilled Nursing Facility Care

Inside our Service Area, we cover at **no charge** skilled inpatient Services in a licensed Skilled Nursing Facility and in accord with Medicare guidelines. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

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

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by Plan Physicians in accord with our drug formulary
- Durable medical equipment in accord with our DME formulary if Skilled Nursing Facilities ordinarily furnish the equipment
- Imaging, laboratory, and special procedures
- Medical social services
- Blood, blood products, and their administration
- Medical supplies
- Services covered under "Physical, Occupational, and Speech Therapy, and Multidisciplinary Rehabilitation Services"
- Respiratory therapy

Designating a Skilled Nursing Facility

Upon discharge from a Plan Hospital, we will cover Skilled Nursing Facility care at the following Skilled Nursing Facilities inside our Service Area, if we have an agreement with the Skilled Nursing Facility to provide you 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
- The Skilled Nursing Facility where your Spouse is residing at the time you are discharged from the hospital

Transplant Services

We cover transplants of organs, tissue, or bone marrow in accord with Medicare guidelines and

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
- 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 is available by calling our Member Service Call Center

For these covered Services, you will pay the Copayments and Coinsurance you would pay if the Services were not related to a transplant.

Vision Services

We cover the Services listed below at Plan Medical Offices or Plan optical sales offices when prescribed by a Plan Physician or Plan optometrist.

Eye exams

Glaucoma screenings in accord with Medicare guidelines and refraction exams to determine the need for vision correction and to provide a prescription for eyeglass lenses are covered at **no charge**.

Optical Services

Eyeglasses and contact lenses. We provide a **$350 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 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 when prescribed by a Plan Physician or Plan optometrist:

- We will provide at **no charge** up to two contact lenses per eye every 12 months to treat aniridia (missing iris)
- We will provide at **no charge** up to five aphakic contact replacement lenses per eye under this or any other *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 under "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. The Allowance is to help you pay for eyeglass lenses, frames, and contact lenses (including fitting, and dispensing). 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 Allowance of $150 following any cataract surgery.

Vision Services exclusions

- Services related to eye surgery or orthokeratologic Services for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism
- Industrial frames
- Lenses and sunglasses without refractive value except for:
  - A balance lens if only one eye needs correction
  - 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 this *DF/EOC*. Additional exclusions that apply only to a particular Service are listed in the description of that Service in either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage.

Certain exams and Services

Physical examinations and other Services (a) required for obtaining or maintaining employment or participation in employee programs, (b) required for insurance or licensing, or (c) 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. Manual manipulation of the spine as covered by Medicare is provided as described under "Outpatient Care" in either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage.

Conception by artificial means

All Services (other than artificial insemination covered under "Infertility Services" in either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage) 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 covered under "Prosthetic and Orthotic Devices" in either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage.

Custodial care

Custodial care means assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine), or 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 either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage.

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 either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage.

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 the promotion, prevention, or other treatment of hair loss or hair growth.

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Hospice Care" in either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage.

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. 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, Post-stabilization, and Urgent Care" in the "Emergency, Urgent, and Routine Care" section, and we will provide coverage and reimbursement as described in that section.

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 Region Members:

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

Southern California Region 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 laws. 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
- 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)

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.

Surrogacy arrangements

You must pay us 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 a woman agrees 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:

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 "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered Services from the following sources:

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

Requests for Payment or Services

Requests for Payment

Non-Plan Emergency Care, Post-stabilization Care, Out-of-Area Urgent Care, and out-of-area dialysis care

If you receive Emergency Care, Post-stabilization Care, Out-of-Area Urgent Care, and out-of-area dialysis care from a Non-Plan Provider (as described in the "Emergency, Urgent, and Routine Care" section about Emergency Care, Post-stabilization Care, and Out-of-Area Urgent Care and in either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage about out-of-area dialysis care), 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, request our claim form by calling our Member Service Call Center at 1-800-443-0815 (*TTY 1-800-777-1370*) or 1-800-390-3510. 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 and receipts from the Non-Plan Provider
- 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 this address:

Northern California Region Members:

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

Southern California Region Members:

Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 7004
Downey, CA 90242-7004

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 appeal 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

Standard decision

If you disagree with your Plan Provider's determination about Services you have requested, or if you want to request that we cover the Services of a Non-Plan Provider, you may request that we provide the Services by 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.

We may extend our decision for up to 14 days if it is in your best 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 as described under "Grievances" 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 best 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 as described in the "Dispute Resolution" section.

You or your physician may request an expedited decision by calling 1-888-987-7247 or by sending your written request 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 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 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 Services representatives are available to discuss your concerns at most Plan Facilities or you can call our Member Service Call Center. The following procedures for resolving disputes are discussed in detail below:

- **Standard Medicare appeal procedure.** To appeal denied claims for payment or denied requests for Services when an expedited Medicare appeal is not required
- **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
- **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
- **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
- **Grievances.** To report any quality of care concerns you have and to seek resolution of an issue that is not subject to a Medicare appeal procedure
- **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 claims for payment or denied requests for Services. **We will use this procedure to reconsider all requests and denied claims unless the Expedited 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 within 60 days from the date of the denial notice (unless you show good cause for a delay past 60 days). Your reconsideration request must be filed in writing with us at the address shown on your denial notice. You have the right to submit any new information to support your request in person or in writing. If you prefer, you may file your request with an office of the Social Security Administration, or if you are a qualified Railroad Annuitant, with the Railroad Retirement Board office. The

office will forward your reconsideration request to us for processing.

For claims for payment, we will process your reconsideration request within 60 days after we receive your request. For denied requests for Services that you believe are covered under this *Agreement*, we will process your reconsideration request within 30 days after we receive your request. If it is in your best interest, or if you request, we may extend the time frame to make 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 time frame, you may file a grievance as described under "Grievances" in this "Dispute Resolution" section.

If our decision is fully in your favor for your request for payment, we will pay for the Services no later than 60 days after we received your reconsideration request. If our decision is fully in your favor for your request for Services, we will authorize or provide the Services as quickly as your health condition requires, but no later than 30 days after we received your reconsideration request.

If we do not rule fully in your favor, we will forward your reconsideration request to the CMS contractor for a decision within 60 days after we receive your request for payment and 30 days after we receive your request for Services (or 44 days as applicable). The CMS contractor, The Center for Health Dispute Resolution (The Center), will then make its own reconsideration decision within 60 days for claims for payment and 30 days for requests for Services. The Center will advise you of its decision and the reason for its decision.

If The Center's decision is in your favor for your request for payment, we will pay for the Services within 30 days after we receive The Center's decision. If The Center's decision is in your favor for your request for Services, we will do one of the following:

- Authorize those Services as quickly as your health condition requires, but no later than 72 hours after we receive notice of The Center's decision
- Provide those Services as quickly as your health condition requires, but no later than 14 days after we receive notice of The Center's decision

If The Center's decision is not fully in your favor, you may request a hearing before an administrative law judge as described under "If You Disagree with The Center's Decision" in this "Dispute Resolution" section.

Expedited Medicare Appeal Procedure

This procedure applies to denied requests for Services that you believe we should provide, arrange, or continue. 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 by calling 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 (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, 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 request, you may file a grievance as described in the "Grievances" section.

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 after we received your reconsideration request.

If our expedited decision is not fully in your favor, we will automatically forward your request for reconsideration to the CMS contractor for a decision within 24 hours of our decision. The CMS contractor, The Center for Health Dispute Resolution (The Center), will then make its own reconsideration decision within 72 hours after The Center receives your case, and so notify you. The Center may extend the time frame to make their decision for an additional 14 days beyond the 72 hours if additional information is needed and the extension is in your best interest. The Center will advise you of its decision and the reason for its decision.

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 after we receive notice of The Center's decision.

If The Center's decision is not fully in your favor, you may request a hearing before an administrative law judge as described under "If You Disagree with The Center's Decision" in this "Dispute Resolution" section.

Supporting Documents

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 supporting information with your reconsideration request, such as medical records or physician opinions. We will obtain medical records from Plan Providers on your behalf. If you have received Services from a Non-Plan Provider, you may 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 appeal and standard Medicare appeal.

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 at the following numbers:

- Health Insurance Counseling and Advocacy Program at 1-800-434-0222 (*TTY 1-800-722-3140*)
- Medicare Rights Center at 1-888-HMO-9050
- State Ombudsman (for skilled nursing facility issues) at 1-800-231-4024
- Area Agency on Aging at 1-800-510-2020 (varies by county, check your phone 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 The Center for Health Dispute Resolution, 1 Fishers Road, Pittsford, NY 14534-9597.

You must file your written request within 60 days of the date of the denial notice from The Center. The administrative law judge may extend the 60-day requirement for good cause. A hearing can be held if the administrative law judge determines that the amount in controversy is $100 or more. An adverse decision by the administrative law judge may be reviewed by the Departmental Appeals Board of the Department of Health and Human Services, either by its own action or as the result of a request from you or us. If the amount involved is $1,000 or more, you or we may request that a federal district court review the Departmental Appeals Board's decision. 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 Departmental Appeals Board may be reopened within 12 months for any case, within four years for just cause, or at any time for fraud cases or clerical correction.

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 from Medicare." 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 after it receives 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 you receive 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 you receive the "Notice of Discharge and Medicare Appeal Rights," if the appeal decision is not in your favor.

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 Lumetra, One Sansome St., Suite 600, San Francisco, CA 94104-4448 (fax number (415) 677-2195), or by calling at 1-800-841-1602 (*TTY 1-800-881-5980)*. 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.

Grievances

You can file a grievance for any issue that is not subject to a Medicare appeal 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 Services representative at a Plan Facility or through our Web site at *www.kaiserpermanente.org.*

We will send you a confirmation letter within five days after we receive your grievance. We will send you our written decision within 30 days after we receive your grievance. 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 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 described under "Expedited decision" in the "Requests for Payment or Services" section
- Deny your request to expedite your Medicare appeal described under "Expedited Medicare Appeal Procedure" in this section
- Decide to extend the time we need to make a standard or an expedited decision described under "Standard decision" or "Expedited decision" in the "Requests for Payment or Services" section and under "Standard Medicare Appeal Procedure" or "Expedited Medicare Appeal Procedure" in this section

If you request an expedited grievance, we will respond to your request within 24 hours.

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 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:

- 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
- 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
- The claim is *not* within the jurisdiction of the Small Claims Court
- If the Member's Group must comply with the Employee Retirement Income Security Act (ERISA) requirements, the claim is *not* a benefit-related request that constitutes a "benefit claim" in Section 502(a)(1)(B) of ERISA. Note: Benefit claims under this Section of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor regulation prohibiting mandatory binding arbitration of this category of claim (29 CFR 2560.503-1(c)(4)) is modified, amended, repealed, superseded, or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without further notice
- The claim is *not* subject to a Medicare appeal procedure

As referred to in this "Binding Arbitration" section, "Member Parties" include:
- A Member
- A Member's heir or personal representative
- Any person claiming that a duty to him or her arises from a Member's relationship to one or more Kaiser Permanente Parties

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

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

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 Region Members:

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

Southern California Region Members:

Kaiser Foundation Health Plan, Inc.
Legal Department
393 East 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 our Member Service Call Center.

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 one Neutral Arbitrator. The Neutral Arbitrator shall not have authority to award monetary damages that are greater than $200,000.

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

Payment of Arbitrator's 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 our Member Service Call Center.

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, (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 a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the Neutral Arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for 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 of California 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, 2005, your last minute of coverage was at 11:59 p.m. on December 31, 2004). 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 a Disabling Condition" in the "Continuation of Membership" section and "Payments after Termination" in this "Termination of Membership" section
- 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, Post-stabilization Care, and Out-of-Area Urgent Care and in either the "Benefits, Copayments, and Coinsurance for Senior Advantage" or the "Benefits, Copayments, and Coinsurance for Senior Advantage MSP" section, as applicable to your coverage about out-of-area dialysis care.

Termination Due to Loss of Eligibility

As described below, if you meet the eligibility requirements described under "Who Is

Eligible" in the "Dues, Eligibility, and Enrollment" 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. For example, if you become ineligible on December 5, 2004, your termination date is January 1, 2005, and your last minute of coverage is at 11:59 p.m. on December 31, 2004.

For information about termination procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Employee

If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month in which premiums are taken from earnings based on an eligible appointment.

Retiree or Survivor

If you are a Retiree or Survivor and your annuity terminates, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for an annuity.

Family Member

If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements.

Loss of Medicare eligibility

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 outside our Service Area
- No longer meet the requirement that you be entitled to Medicare Part B. Your Senior Advantage membership termination will be effective the first day of the month following the month when Medicare Part B ends

For Senior Advantage MSP Members, in addition, we will terminate your membership under this *DF/EOC* when Medicare coverage becomes primary, for example, when you retire. If you continue to meet the eligibility requirements of our regular Senior Advantage plan (which does not require that Medicare be secondary coverage), you will be able to continue your Senior Advantage membership with different Dues, benefits, and Copayments either through your Group (if available) or as discussed under "Conversion to an Individual Plan" in the "Continuation of Membership" section.

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.

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 *Group Agreement* with us terminates.

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, please 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 after we receive your written request, and no later than three months after we receive 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 at 1-800-MEDICARE (1-800-633-4227) (*TTY 1-877-486-2048*) 24 hours a day, seven days a week. 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 Region Members:

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

Southern California Region Members:

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

Note: If you enroll in another Medicare Advantage 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. **For Senior Advantage Members,** 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 Advantage plan.

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 misrepresent membership status, misuse (or let someone else use) a Member ID card, or commit fraud in connection with your obtaining membership

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

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 (HIPAA) 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 unless your Group has an agreement with us to mail the certificates. If you have any questions, please contact your Group's benefits administrator.

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
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with "Non-Plan Emergency Care, Post-stabilization Care, Out-of-Area Urgent Care, and out-of-area dialysis 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

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.

COBRA – Continuation of Group Coverage

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 may be eligible for COBRA continuation coverage even if they live in (or move to) 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 to an Individual Plan," 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.

Note: For more information about COBRA, please refer to the University of California notice "Continuation of Group Insurance Coverage," available from the University's "At Your Service" Web site (http://atyourservice.ucop.edu). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center. You may also direct questions about these provisions to your local Benefits Office or to the University's Customer Service Center if you are a Retiree.

Leave of Absence, Layoff, or Retirement

For Senior Advantage MSP Members, please contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff, or retirement.

Conversion to an Individual Plan

After your Group notifies us to terminate your membership, we will send a termination letter to the Subscriber's address of record. The letter will include information about options that may be available to you to remain a Health Plan member 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 under "Who Is Eligible" in the "Dues, Eligibility, and Enrollment" 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 our non-Medicare individual plan, called "Kaiser Permanente Individual–Conversion Plan." You may be eligible to enroll in our Individual–Conversion Plan if we receive your enrollment application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later). You are not eligible to convert if your membership ends because we terminated your membership under "Termination for Cause" in the "Termination of Membership" section.

For information about converting your membership or about other individual plans, call our Member Service Call Center.

Coverage for a Disabling Condition

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
- 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 Deductibles, 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 your Group's *Agreement* with us terminates.

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

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

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

Agreement binding on Members

By electing coverage or accepting benefits under this *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 of California's Group's *Agreement* with us will change periodically. If these changes affect this *DF/EOC*, your Group is required to inform you in accord with applicable law and the *Group Agreement*.

Applications and statements

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

Attorneys' 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 that is required to be in this *DF/EOC* by state or

federal law shall bind Members and Health Plan whether or not set forth in this *DF/EOC*.

Group and Members not our agents

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

Health Insurance Counseling and Advocacy Program (HICAP)

For additional information concerning benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. HICAP provides health insurance counseling for California senior citizens. Call the HICAP telephone number, 1-800-434-0222 (*TTY 1-800-722-3140*), for a referral to your local HICAP office. HICAP is a free service provided by the state of California.

Named fiduciary

Under our *Agreement* with the University of California, 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 your 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, and Social Security at 1-800-772-1213, as soon as possible to report the address change. If a Member does not reside with the Subscriber, he or she should contact our Member Service Call Center to discuss alternate delivery options.

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

Other formats for the visually impaired

If you are visually impaired, you may request a copy of this *DF/EOC* in an alternate format by calling our Member Service Call Center.

Overpayment recovery

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

Privacy practices

Kaiser Permanente will protect the privacy of your Protected Health Information (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. You can also find the notice at your local Plan Facility or on our Web site at *www.kaiserpermanente.org*.

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 these source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this document 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 document and/or the Group Hospital and Professional Service Agreement. What is written in this document 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
1-800-888-8267

Retirees 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 Region Members:
Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 12923
Oakland, CA 94604-2923
1-800-390-3510 or 1-800-464-4000

Southern California Region Members:
Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 7004
Downey, CA 90242-7004
1-800-390-3510 or 1-800-464-4000

Group Contract Numbers

Northern California Region

The Group contract number for the University of California, Northern California Region, is 7

Southern California Region

The Group contract numbers for the University of California, Southern California Region, are 102601, 102602, 102603, 102604, 102605, 102607, 102608, 102609, 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, Retirees, 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 premiums that 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 by Kaiser Foundation Health Plan, Inc., under a Group Service Agreement. The cost of the premiums is currently shared between you and the University of California.

Agent for Serving of Legal Process

Legal process may be served on Kaiser Foundation Health Plan, Inc., at the following address:

Northern California Region Members:
Kaiser Foundation Health Plan, Inc.
Legal Department
P.O. Box 12916
Oakland, CA 94604

Southern California Region Members:
Kaiser Foundation Health Plan, Inc.
Legal Department
393 East Walnut Street
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 Service 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 "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 of Diversity and Employee Programs
University of California
Office of the President
300 Lakeside Drive
Oakland, CA 94612

and for faculty to:

Director of Academic Affirmative Action
University of California
Office of the President
1111 Franklin Street
Oakland, CA 94607

Member Service Call Center

1-800-443-0815
7 a.m. to 7 p.m.
Seven days a week (except holidays)

1-800-777-1370 (TTY for the hearing/speech impaired)

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