

Help in your language

Interpreters are available 24 hours a day, seven days a week, at no cost to you. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may be able to get materials written in your language. For more information, call our Member Service Call Center at 1-800-464-4000 or 1-800-777-1370 (TTY) weekdays from 7 a.m. to 7 p.m., and weekends from 7 a.m. to 3 p.m.

Ayuda en su propio idioma

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

語言翻譯協助

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

TABLE OF CONTENTS

2010 Summary of Changes and Clarifications	1
Changes to the <i>EOC</i> document.....	1
Clarifications to the <i>EOC</i> document.....	2
Benefit Highlights	4
Introduction	6
Term of this <i>Evidence of Coverage</i>	6
About Kaiser Permanente.....	6
Definitions.....	6
Premiums, Eligibility, and Enrollment.....	10
Premiums.....	10
Who Is Eligible.....	10
When You Can Enroll and When Coverage Begins.....	14
How to Obtain Services.....	16
Routine Care.....	16
Urgent Care	17
Our Advice Nurses	17
Your Personal Plan Physician	17
Getting a Referral	17
Second Opinions.....	19
Contracts with Plan Providers	20
Visiting Other Regions.....	20
Your ID Card.....	20
Getting Assistance.....	21
Plan Facilities	21
Plan Hospitals and Plan Medical Offices	21
<i>Your Guidebook to Kaiser Permanente Services (Your Guidebook)</i>	25
Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers.....	25
Prior Authorization.....	26
Emergency Care	26
Post-Stabilization Care	26
Out-of-Area Urgent Care.....	27
Services Not Covered Under this "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" Section.....	27
Payment and Reimbursement	27
Benefits and Cost Sharing	28
Cost Sharing	28
Preventive Care Services	30
Outpatient Care	30
Hospital Inpatient Care.....	31
Ambulance Services	32
Chemical Dependency Services	32
Dental Services for Radiation Treatment and Dental Anesthesia.....	33
Dialysis Care	33
Durable Medical Equipment for Home Use	33
Health Education	35
Hearing Services.....	35
Home Health Care.....	35
Hospice Care	36
Infertility Services	37

Mental Health Services	37
Ostomy and Urological Supplies	38
Outpatient Imaging, Laboratory, and Special Procedures	38
Outpatient Prescription Drugs, Supplies, and Supplements	39
Prosthetic and Orthotic Devices	41
Reconstructive Surgery	42
Services Associated with Clinical Trials	42
Skilled Nursing Facility Care	43
Transgender Surgery	43
Transplant Services	44
Exclusions, Limitations, Coordination of Benefits, and Reductions	44
Exclusions	44
Limitations	46
Coordination of Benefits	47
Reductions	47
Dispute Resolution	49
Grievances	49
Supporting Documents	50
Who May File	50
Department of Managed Health Care Complaints	51
Independent Medical Review (IMR)	51
Binding Arbitration	52
Termination of Membership	54
Termination Due to Loss of Eligibility	54
Termination of <i>Agreement</i>	54
Termination for Cause	55
Termination for Nonpayment	55
Termination of a Product or all Products	56
HIPAA Certificates of Creditable Coverage	56
Payments after Termination	56
State Review of Membership Termination	56
Continuation of Membership	56
Continuation of Group Coverage	56
Conversion from Group Membership to an Individual Plan	59
Leave of Absence, Layoff or Retirement	60
Miscellaneous Provisions	60
Plan Administration	63
Sponsorship and Administration of the Plan	63
Group Contract Numbers	63
Type of Plan	63
Continuation of the Plan	63
Financial Arrangements	64
Agent for Serving of Legal Process	64
Your Rights under the Plan	64
Claims under the Plan	64
Nondiscrimination Statement	64

2010 Summary of Changes and Clarifications

The following is a summary of changes and clarifications that we have made to this *Evidence of Coverage (EOC)* document. This summary does not include minor changes and clarifications that Health Plan is making to improve the readability and accuracy of the Agreement and any changes we have made at your Group's request. Please refer to the "Premiums" section in the *Group Agreement* for the Premiums that are effective on your Group's renewal anniversary date.

Unless otherwise indicated, the changes will be effective on your Group's renewal anniversary date and apply to each type of coverage purchased by your Group. Please read the *Agreement* for the complete text of these changes.

Note: In this document "non-Medicare EOCs" means all EOCs other than Senior Advantage or Medicare Cost EOCs.

Changes to the EOC document

Mental health and chemical dependency Services

In response to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (PL 110-343), we are making the following changes to mental health and chemical dependency coverage:

- *There will no longer be any outpatient visit or inpatient day limits for mental health or chemical dependency Services*
- *If hospital inpatient care is covered at "no charge," transitional residential recovery Services will also be covered at "no charge" (previously these Services were covered at a \$100 Copayment per admission)*
- *If the Cost Sharing for mental health or chemical dependency Services was greater than the Cost Sharing for other inpatient or outpatient Services, the Cost Sharing will now be equal to or less than the Cost Sharing for other Services*
- *All covered mental health and chemical dependency Services will apply to the annual out-of-pocket maximum*

If your Group offers coverage through a group health plan that is for retirees only (as indicated on your Form 5500 filing with the Department of Labor), and there are fewer than two active employees enrolled in that plan, mental health and chemical dependency coverage under that plan is not required to comply with the Act. If your Group has a plan that meets these requirements and you do not want Health Plan to apply the benefit changes described above to that plan, please contact your Health Plan account manager.

Newborn eligibility period

Effective January 1, 2010, newborns are covered from birth for 31 days after the birth (including the date of birth). Previously, newborn coverage extended through the calendar month of birth, or the mother's hospitalization if she is a Member, whichever is later. We are making this change for consistency with industry practice. The deadline for enrolling newborns is not changing.

Service Area expansion

In non-Medicare EOCs, the Service Area of our Southern California Region now includes additional parts of Kern County in the 93249 ZIP code (the Lost Hills area). Members may obtain care from Plan Providers in the Bakersfield area.

Special enrollment

Effective April 1, 2009, the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 requires groups to permit eligible employees or dependents to enroll in group coverage when CHIP or Medicaid coverage terminates due to loss of eligibility, and the employee requests coverage within 60 days after CHIP or Medicaid coverage terminates. California law already requires groups to offer special enrollment to persons who lose eligibility for CHIP (known as Healthy Families in California) and Medicaid (known as Medi-Cal in California), but the timeframe for requesting enrollment is 30 days under California law. *We have revised the "Special enrollment due to loss of other coverage" section of non-Medicare EOCs to reflect the 60 day special enrollment period required by the CHIP Reauthorization Act.*

In non-Medicare EOCs, we have made the following changes to the "Special enrollment" section for consistency with state and federal requirements related to special enrollment:

- We have clarified that the Subscriber may enroll with or without *Dependents if eligible for special enrollment* due to acquisition of new Dependents
- We have added examples of special enrollment due to loss of other coverage
- We have clarified that *establishment of a domestic partnership* is a qualifying event for special enrollment due to new Dependents

Student Medical Leave of Absence

If a group covers dependent children, and the age limit for students is higher than for other dependent children, the definition of "student" has been revised for eligibility purposes. *Dependent students on a medically necessary leave of absence from school will continue to be eligible for coverage as students for up to one year.* Breaks in the school calendar will not disqualify the dependent student from coverage. We are making this change in response to SB 1168 and HR 2851.

Clarifications to the EOC document

Assistance with ERISA compliance

Under the Employee Retirement Income Security Act (ERISA), the plan administrator of an ERISA-covered employee welfare benefit plan is responsible, among other things, for development and distribution of a *Summary Plan Description (SPD)* to plan participants. The plan administrator can satisfy certain ERISA disclosure requirements by incorporating the Health Plan *EOC* into the *SPD*. To assist groups with ERISA compliance, we are making the following changes to non-Medicare *EOCs*:

- We have moved information about post-service claims for Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care to the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section
- We have moved information about all other post-service claims, pre-service claims, and concurrent care claims to the "Dispute Resolution" section
- We have added a notice about the Women's Health and Cancer Rights Act and the Newborns' and Mothers' Health Protection Act to the "Miscellaneous Provisions" section

We are also providing an ERISA information sheet with the cover letter that accompanies your new *Agreement*. The ERISA information sheet is intended to help plan administrators ensure that their *SPD* accurately reflects the terms of their fully-insured group health care coverages, as required under ERISA.

Claims and grievance timeframes

We have revised the description of the process for filing claims for Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care from Non-Plan Providers to clarify that different timeframes apply if your Group is not subject to ERISA. We will respond to these claims as follows:

- If your Group must comply with ERISA, we will send our written decision within 30 calendar days after we receive the claim unless we request additional information from you or the Non-Plan Provider. If we request additional information, we will send our written decision no later than 15 calendar days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in the letter, we will make our decision based on the information we have
- If your Group is not subject to ERISA, we will send our written decision within 45 business days after we receive the claim unless we request additional information from you or the Non-Plan Provider. If we request additional information, we will send our written decision no later than 45 business days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in the letter, we will make our decision based on the information we have

Medicare secondary payer

In non-Medicare *EOCs*, we have clarified that when Group coverage is primary and Medicare coverage is secondary, Senior Advantage Members are also entitled to the same group benefits under the same terms as Members who are not eligible for Medicare, as described in your Group's non-Medicare *EOC* for that Member. When Medicare coverage is

secondary, Senior Advantage Members must refer to both their Senior Advantage and non-Medicare *EOCs* for the full description of their coverages, which are coordinated in accord with applicable law.

Moving to the other California Region

We have clarified that if your Group has an arrangement with us that permits membership in the Northern California Region and a Member moves to that Region, all terms and conditions of the Member's application for enrollment in the Southern California Region, including the Arbitration Agreement, will continue to apply.

Nondiscrimination

We have revised the nondiscrimination provision to indicate that Health Plan does not discriminate on the basis of genetic information. We are making this change in response to the Genetic Nondiscrimination Act (PL 110-233). This does not represent a change in practice.

Residential care exclusion

We have clarified that care in a facility where a Member stays overnight is excluded, except that the exclusion does not apply when the overnight stay is part of the following covered care:

- Care in a hospital
- Care in a Skilled Nursing Facility
- Inpatient respite care covered under the "Hospice Care" section
- Care in a licensed facility providing crisis residential Services covered under "Intensive psychiatric treatment programs" in the "Mental Health Services" section
- Care in a licensed facility providing transitional residential recovery Services (or residential rehabilitation, if covered) under the "Chemical Dependency Services" section

Vaccines

In non-Medicare *EOCs*, we have clarified that when supplemental drugs are covered, self-administered vaccines are covered under the "Outpatient Prescription Drugs, Supplies, and Supplements" section. Vaccines that are administered in Plan Medical Office are covered under the "Outpatient Care" section.

Benefit Highlights

Annual Out-of-Pocket Maximum for Certain Services

For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member)	\$1,500 per calendar year
For any one Member in a Family of two or more Members	\$1,500 per calendar year
For an entire Family of two or more Members	\$3,000 per calendar year

Deductible	None
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Lifetime Maximum

Services covered under "Transgender Surgery" in the "Benefits and Cost Sharing" section	\$75,000
All other Services	None

Professional Services (Plan Provider office visits) **You Pay**

Routine preventive care:	
Physical exams	\$15 per visit
Well-child visits (through age 23 months)	No charge
Family planning visits	\$15 per visit
Scheduled prenatal care visits and first postpartum visit	No charge
Eye exams for refraction	\$15 per visit
Hearing tests	\$15 per visit
Flexible sigmoidoscopies	\$15 per visit
Primary and specialty care visits	\$15 per visit
Urgent care visits	\$15 per visit
Physical, occupational, and speech therapy	\$15 per visit

Outpatient Services **You Pay**

Outpatient surgery and certain other outpatient procedures	\$15 per procedure
Allergy injection visits	\$5 per visit
Allergy testing visits	\$15 per visit
Most vaccines (immunizations)	No charge
X-rays and lab tests	No charge
Health education:	
Individual visits	\$15 per visit
Group educational programs	No charge

Hospitalization Services **You Pay**

Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	\$250 per admission
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Emergency Health Coverage **You Pay**

Emergency Department visits	\$50 per visit
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Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient (see "Hospitalization Services" for inpatient Cost Sharing).

Ambulance Services **You Pay**

Ambulance Services	No charge
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Prescription Drug Coverage **You Pay**

Most covered outpatient items in accord with our drug formulary guidelines:

Generic items from a Plan Pharmacy	\$5 for up to a 30-day supply, \$10 for a 31- to 60-day supply, or \$15 for a 61- to 100-day supply
Generic refills from our mail-order service	\$5 for up to a 30-day supply or \$10 for a 31- to 100-day supply

Prescription Drug Coverage	You Pay
Brand-name items from a Plan Pharmacy	\$20 for up to a 30-day supply, \$40 for a 31- to 60-day supply, or \$60 for a 61- to 100-day supply
Brand-name refills from our mail-order service	\$20 for up to a 30-day supply or \$40 for a 31- to 100-day supply
Durable Medical Equipment	You Pay
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	No charge
Mental Health Services	You Pay
Inpatient psychiatric hospitalization and intensive psychiatric treatment programs	\$250 per admission
Outpatient individual and group visits	\$15 per individual visit \$7 per group visit
Chemical Dependency Services	You Pay
Inpatient detoxification	\$250 per admission
Outpatient individual visits	\$15 per visit
Outpatient group visit	\$5 per visit
Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge
Other	You Pay
Hearing aid(s) every 36 months	Amount in excess of \$1,000 Allowance per aid
Skilled Nursing Facility care (up to 100 days per calendar year)	No charge
All covered Services related to infertility treatment	50% Coinsurance
Hospice care	No charge

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

Introduction

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

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

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

Term of this *Evidence of Coverage*

This *Evidence of Coverage* is for the period January 1, 2010, through December 31, 2010, unless amended. Your Group can tell you whether this *Evidence of Coverage* is still in effect and give you a current one if this *Evidence of Coverage* has expired or been amended.

About Kaiser Permanente

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

We provide covered Services to Members using Plan Providers located in our Service Area, which is described

in the "Definitions" section. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

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

Definitions

When capitalized and used in any part of this *Evidence of Coverage*, these terms have the following meanings:

Allowance: A specified credit amount 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 amount in excess of the Allowance (and that payment does not apply toward your annual out-of-pocket maximum).

Charges: Charges means the following:

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

the amount Kaiser Permanente would have paid if it did not subtract Cost Sharing

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.

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

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

Cost Sharing: The Copayment or Coinsurance you are required to pay for a covered Service.

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 "Premiums, Eligibility, and Enrollment" section).

Emergency Care:

- Evaluation by a physician (or other appropriate personnel under the supervision of a physician to the extent provided by law) to determine whether you have an Emergency Medical Condition
- Medically Necessary Services required to make you Clinically Stable within the capabilities of the facility
- Emergency ambulance Services covered under "Ambulance Services" in the "Benefits and Cost Sharing" section

Emergency Medical Condition: Either: (1) 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 serious jeopardy to your health or body functions or organs; or (2) active labor when there isn't enough time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety.

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

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

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

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

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

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

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

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

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

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

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:

- You are temporarily outside our Service Area

- You reasonably believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to our Service Area

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

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

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

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

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

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

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

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

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

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group

designates as Primary Care Physicians. Please refer to our Web site at kp.org for a list of Primary Care Physicians, except that the list is subject to change without notice. For the current list of physicians that are available as Primary Care Physicians, please call the personal physician selection department at the phone number listed in *Your Guidebook*.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. For information about Region locations in the District of Columbia, 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 are also inside our Service Area, as indicated by the ZIP codes below for each county:

- 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, 93720–30, 93741, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–80, 93784, 93786, 93790–94, 93844, 93888
- Kings: 93230, 93232, 93242, 93631, 93656
- Madera: 93601–02, 93604, 93614, 93623, 93626, 93636–39, 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, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–36, 95138–

41, 95148, 95150–61, 95164, 95170, 95172–73,
95190–94, 95196

- Sonoma: 94515, 94922–23, 94927–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, 95492
- Sutter: 95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 95836, 95837
- Tulare: 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
- Yolo: 95605, 95607, 95612, 95616–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99
- Yuba: 95692, 95903, 95961

*Exception: Knoxville is not in our Service Area.

Southern California Region Service Area

Orange County is entirely inside our Service Area.

Portions of the following counties are also inside our Service Area, as indicated by the ZIP codes below for each county:

- Imperial: 92274–75
- Kern: 93203, 93205–06, 93215–16, 93220, 93222, 93224–26, 93238, 93240–41, 93243, 93249–52, 93263, 93268, 93276, 93280, 93285, 93287, 93301–09, 93311–14, 93380, 93383–90, 93501–02, 93504–05, 93518–19, 93531, 93536, 93560–61, 93581
- Los Angeles: 90001–84, 90086–91, 90093–96, 90101, 90103, 90189, 90201–02, 90209–13, 90220–24, 90230–33, 90239–42, 90245, 90247–51, 90254–55, 90260–67, 90270, 90272, 90274–75, 90277–78, 90280, 90290–96, 90301–12, 90401–11, 90501–10, 90601–10, 90623, 90630–31, 90637–40, 90650–52, 90660–62, 90670–71, 90701–03, 90706–07, 90710–17, 90723, 90731–34, 90744–49, 90755, 90801–10, 90813–15, 90822, 90831–35, 90840, 90842, 90844, 90846–48, 90853, 90895, 91001, 91003, 91006–12, 91016–17, 91020–21, 91023–25, 91030–31, 91040–43, 91046, 91066, 91077, 91101–10, 91114–18, 91121, 91123–26, 91129, 91182, 91184–85, 91188–89, 91199, 91201–10, 91214, 91221–22, 91224–26, 91301–11, 91313, 91316, 91321–22, 91324–31, 91333–35, 91337, 91340–46, 91350–57, 91361–62, 91364–65, 91367, 91371–72, 91376, 91380–81, 91383–87, 91390, 91392–96, 91401–13, 91416, 91423, 91426, 91436, 91470, 91482, 91495–96, 91499, 91501–08, 91510, 91521–23, 91601–12, 91614–18, 91702, 91706, 91709, 91711, 91714–16, 91722–24, 91731–35, 91740–41, 91744–50, 91754–56, 91759, 91765–73, 91775–76, 91778, 91780,

91788–93, 91795, 91801–04, 91896, 93243, 93510, 93532, 93534–36, 93539, 93543–44, 93550–53, 93560, 93563, 93584, 93586, 93590–91, 93599

- Riverside: 91752, 92201–03, 92210–11, 92220, 92223, 92230, 92234–36, 92240–41, 92247–48, 92253, 92255, 92258, 92260–64, 92270, 92274, 92276, 92282, 92292, 92320, 92324, 92373, 92399, 92501–09, 92513–19, 92521–22, 92530–32, 92543–46, 92548, 92551–57, 92562–64, 92567, 92570–72, 92581–87, 92589–93, 92595–96, 92599, 92860, 92877–83
- San Bernardino: 91701, 91708–10, 91729–30, 91737, 91739, 91743, 91758, 91761–64, 91766, 91784–86, 91792, 92252, 92256, 92268, 92277–78, 92284–86, 92305, 92307–08, 92313–18, 92321–22, 92324–26, 92329, 92331, 92333–37, 92339–41, 92344–46, 92350, 92352, 92354, 92357–59, 92369, 92371–78, 92382, 92385–86, 92391–95, 92397, 92399, 92401–08, 92410–15, 92418, 92423–24, 92427, 92880
- San Diego: 91901–03, 91908–17, 91921, 91931–33, 91935, 91941–47, 91950–51, 91962–63, 91976–80, 91987, 92007–11, 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, 92126–32, 92134–40, 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, 93001–07, 93009–12, 93015–16, 93020–22, 93030–36, 93040–44, 93060–66, 93094, 93099, 93252

For each ZIP code listed for a county, our Service Area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside our Service Area, unless either (1) that other county is entirely in our Service Area as listed above, or (2) that other county is also listed above and that ZIP code is also listed for that other county.

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

Services: Health care services or items.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial

care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Spouse: Your legal husband or wife. For the purposes of this *Evidence of Coverage*, the term "Spouse" includes your registered domestic partner who meets all of the requirements of Section 297 of the California Family Code, or your domestic partner in accord with your Group's requirements, if any.

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

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

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

Premiums, Eligibility, and Enrollment

Premiums

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

Who Is Eligible

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

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.

Anyone enrolled in a non-University Medicare Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be disenrolled from this health plan.

Group eligibility requirements

You must meet the University of California's eligibility requirements that we have approved. The University 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" below.

Service Area eligibility requirements

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

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

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

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

- **Regions outside California.** You may be able to enroll in the service area of another Region if there is an agreement between your Group and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same. For the purposes of this eligibility rule, the Regions outside California may change on January 1 of each year and are currently the District of Columbia and parts of Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington
- **Our Northern California and Southern California Region's service area.** When you join Kaiser Permanente, you are enrolling in one of two California Regions (Northern California Region or Southern California Region), which we call your Home Region. The coverage information in this *Evidence of Coverage* applies when you obtain care in your Home Region. All terms and conditions in

your application for enrollment in either the Northern California or Southern California Region, including the Arbitration Agreement, will continue to apply if the Subscriber does not submit a new enrollment form. When you visit the other California Region, you may receive care as described in “Visiting other Regions” in the “How to Obtain Services” section.

For more information about the service areas of the other Regions, please call our Member Service Call Center. For the purposes of this eligibility rule, the service areas of the Regions outside California may change on January 1 of each year and are currently the District of Columbia and parts of Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington. For more information, please call our Member Service Call Center.

Note: You may be able to receive certain care if you are visiting the service area of another Region. See "Visiting Other Regions" in the "How to Obtain Services" section for information.

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-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.

** Average Regular Paid Time - For any month, the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked in the preceding twelve (12) month period. Average regular paid time does not include full or partial months of zero paid hours when an employee works less than 43.75% of the regular paid hours available in the month due to furlough, leave without pay or initial employment.

Retiree (including Survivor)

Retiree. A former University Employee 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. You must also meet the following requirements:

- you meet the University's service credit requirements for Retiree medical eligibility;
- 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
- you elect to continue (or effective 1/1/05 suspend) medical coverage at the time of retirement.

Survivor. a deceased Employee's or Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan—may be eligible to continue coverage as set forth in the University's Group Insurance Regulations. For more information, see the *UC Group Insurance Eligibility Fact sheet for Retirees and Eligible Family Members* or the *Survivor and Beneficiary Handbook*.

If you are eligible for Medicare, you must follow UC's Medicare Rules. See "Effect of Medicare on Retiree Enrollment" below.

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. The University and/or the Health Plan reserves 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 except for a child who is incapable of self-support due to a physical or mentally disabling injury, illness or condition), unmarried, and may not be emancipated minors. The following categories are eligible:

- your natural or legally adopted children;

- 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;
- 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;
- 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.
- children for whom you are legally required to provide group health insurance pursuant to an administrative or court order. (Child must also meet UC eligibility requirements.)

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

- the plan-certified incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous;
- the child is chiefly dependent upon you for support and maintenance;
- 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 which may offset the Social Security or Supplemental Security Income; and
- the child lives with you (unless he or she is your natural or adopted child).

Application for coverage beyond age 23 due to disability must be made to the Health Plan sixty days prior to the date coverage is to end due to reaching limiting age. If application is received timely but Health Plan does not complete determination of the child's continuing eligibility by the date the child reaches the Health Plan's upper age limit, the child will remain covered pending Health Plan's determination. The Health Plan may periodically request proof of continued disability, but not more than once a year after the initial certification. 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; however, the new Health Plan

may require proof of continued disability, but not more than once a year.

If you are a newly hired Employee with an incapacitated child over age 23 or if you newly acquire an incapacitated child over age 23 (through marriage or adoption), you may also apply for coverage for that child. The child's incapacity must have begun prior to the child turning age 23. Additionally, 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. The Health Plan will ask for proof that the child is incapable of self-support due to a physical or mentally disabling injury, illness or condition, but not more than once a year after the initial certification.

Other eligible Dependents (Family Members)

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

The University recognizes 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. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003 and continues to be ineligible for Social Security may continue coverage in UC-sponsored plans.

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.

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

also access eligibility factsheets on UC's *At Your Service* web site: <http://atyourservice.ucop.edu>.

Persons barred from enrolling

You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause. Note: A Family Member who commits fraud or deception or on whose behalf you commit fraud or deception will be permanently disenrolled. If you commit fraud or deception, you and any eligible Family Members will be disenrolled for 12 months.

Effect of Medicare on Retiree enrollment and retirees

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 employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan.

Retirees or their Family Member(s) who become eligible for premium-free Medicare Part A on or after January 1, 2004 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 between July 1, 1991 and January 1, 2004, but declined to enroll in Part B of Medicare, are 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 required to enroll in Part B, they will not be assessed an offset fee, nor will they 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.)

An exception to the above rules applies to Retirees or Family Members in the following categories who will be eligible for the non-Medicare premium applicable to this plan and will also be eligible for the benefits of this plan without regard to Medicare:

- Individuals who were eligible for premium-free Part A, but not enrolled in Medicare Part B prior to July 1, 1991.
- Individuals who are not eligible for premium-free Part A.

You should contact Social Security three months before your or your Family Member's 65th birthday to inquire about your eligibility and how to enroll in Part A and Part B 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 UC Customer Service Center or from the web site: <http://atyourservice.ucop.edu>. Completed forms should be returned to University of California, Human Resources, Retiree Insurance Program, Post Office Box 24570, Oakland, CA 94623-1570.

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care contract must assign his/her Medicare benefit (including Part D) to that plan or lose UC-sponsored medical coverage. Anyone enrolled concurrently in a non-University Medicare Advantage Managed Care contract will be disenrolled from this health plan. Any individual enrolled in a University-sponsored Medicare Part D Prescription Drug Plan must assign his/her Part D benefit to the plan or lose UC-sponsored medical coverage. Anyone enrolled concurrently in a non-University Medicare Part D Prescription Drug Plan will be disenrolled from this health plan.

When Medicare is secondary. The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. Employees or their spouses, age 65 or over, and UC Retirees re-hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For those eligible for a group health plan due to employment, MSP indicates that Medicare becomes the secondary payer and the employer plan becomes the primary payer. You and your spouse should carefully consider the impact on your health benefits and premiums at age 65 or should you decide to return to work after you retire. Continued employment past age 65 may delay enrollment into Part B, however, once enrolled, Part B must be continuous.

must be completed by the deadline on the last day of the enrollment period.

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

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

When You Can Enroll and When Coverage Begins

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

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 UC 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 UC Customer Service Center by the last business day within the applicable enrollment period; electronic transactions

During a Period of Initial Eligibility (PIE)

A PIE begins the day you become eligible and ends 31 days after it began (but see exception under "Special Circumstances" paragraph 1.d below). Also see "At Other Times for Employees and Retirees" below.

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 in which you are enrolled.

- For a spouse, on the date of marriage.
- For a Domestic Partner, on the date the domestic partnership is legally established. Also see "At Other Times for Employees and Retirees" below.
- For a natural child, on the child's date of birth.
- For an adopted child, the earlier of:
 - ◆ the date you or your Spouse or Domestic Partner has the legal right to control the child's health care, or
 - ◆ 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.
- Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you are in a Health Maintenance Organization (HMO), and you move or are transferred out of that Health Plan's service area, or will be away from the Health 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 Health Plan's service area.

At other times for Employees and Retirees

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

90-Day Waiting Period. 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 unless one of the “Special Circumstances” described below applies.

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 unless one of the “Special Circumstances” described below applies.

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.

Newly Eligible Child. If you have one or more children enrolled in the Health Plan, you may add a newly eligible Child at any time. See “Effective Date”.

Special Circumstances. You may enroll before the end of the 90-day waiting period or without waiting for the University’s next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:
 - a. You were covered under another health plan as an individual or dependent, including coverage under COBRA or CalCOBRA (or similar program in another state), the Children’s Health Insurance Program or “CHIP” (called the Healthy Families Program in California), or Medicaid (called Medi-Cal in California).
 - b. You stated at the time you became eligible for coverage under this Health Plan that you were declining coverage under this Health Plan or disenrolling because you were covered under another health plan as stated above.

- c. Your coverage under the other health plan wherein you or your eligible Family Members were covered as an individual or dependent ended because you lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, your coverage under COBRA or CalCOBRA continuation was exhausted, or you lost coverage under CHIP or Medicaid because you were no longer eligible for those programs.
 - d. You properly file an application with the University during the PIE which starts on the day after the other coverage ends. **Note that if you lose coverage under CHIP or Medicaid, your PIE is 60 days.**
2. A court has ordered coverage be provided for a spouse, domestic partner or dependent child under your UC-sponsored medical plan and an application is filed within the PIE which begins the date the court order is issued. (Family member(s) must also meet UC eligibility requirements.)
 3. You have a change in family status through marriage or domestic partnership, or the birth, adoption, or placement for adoption of a child:
 - a. If you are enrolling following marriage or establishment of a domestic partnership, you and your new spouse or domestic partner must enroll during the PIE. Your new spouse or domestic partner’s eligible children may also enroll at that time. Coverage will be effective as of the date of marriage or domestic partnership provided you enroll during the PIE.
 - b. If you are enrolling following the birth, adoption, or placement for adoption of a child, your spouse (if you are already married) or domestic partner, who is eligible but not enrolled, may also enroll at that time. Application must be made during the PIE; coverage will be effective as of the date of birth, adoption, or placement for adoption provided you enroll during the PIE.
 4. You meet or exceed a lifetime limit on all benefits under another health plan. Application must be made within 31 days of the date a claim or a portion of a claim is denied due to your meeting or exceeding the lifetime limit on all benefits under the other plan. Coverage will be effective on the first day of the month following the date you file the enrollment application.

If you are an Employee or a Retiree and there is a lifetime maximum for all benefits under this plan, and you or a Family Member reaches that maximum, you and your eligible Family Members may be eligible to enroll in another UC-sponsored medical plan. Contact the person who handles benefits at your location (or the UC Customer Service Center if you are a Retiree).

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan (or its Medicare version) you were enrolled in immediately before retiring, and you may change your plan during the University's next open enrollment period. 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). Retirement alone does not grant a PIE nor allow the changing of your medical plan.

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

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

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:

- the date the Child becomes eligible, or
- a maximum of 60 days prior to the date your Child's enrollment transaction is completed.

Change in coverage

In order to make any of the changes described above, contact the person who handles benefits at your location (or the UC Customer Service Center if you are a Retiree).

How to Obtain Services

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

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

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

Routine Care

If you need to make a routine care appointment, please refer to *Your Guidebook to Kaiser Permanente Services (Your Guidebook)* for appointment telephone numbers, or go to our Web site at kp.org to request an appointment online. Routine appointments are for medical needs that aren't urgent (such as routine preventive care and school physicals). Try to make your routine care appointments as far in advance as possible.

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.

For information about Out-of-Area Urgent Care, please refer to the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section.

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 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, tell you what to do if a Plan Medical Office is closed, 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.

Your Personal Plan Physician

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

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

To learn how to select a personal Plan Physician, please refer to *Your Guidebook* or call our Member Service Call Center. You can find a directory of our Plan Physicians

on our Web site at **kp.org**. For the current list of physicians that are available as Primary Care Physicians, please call the personal physician selection department at the phone number listed in *Your Guidebook*. You can change your personal Plan Physician for any reason.

Getting a Referral

Referrals to Plan Providers

A Plan Physician must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, urology, and dermatology. However, you do not need a referral to receive care from any of the following:

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

Medical Group authorization procedure for certain referrals

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

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

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

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

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

Medical Group's decision time frames. The applicable Medical Group designee will make the authorization decision within the time frame appropriate for your condition, but no later than five business days after

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

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your physician will be informed of the scope of the authorized Services. If the Medical Group does not authorize all of the Services, 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 that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request.

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

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

Completion of Services from Non-Plan Providers

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

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

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

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

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

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

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

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

Second Opinions

If you request a second opinion, it will be provided to you when Medically Necessary 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. Here are some examples of when a second opinion is Medically Necessary:

- 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

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 Physician. If the Medical Group determines that there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, the Medical Group will authorize a referral to a Non-Plan Physician for a Medically Necessary second opinion.

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

Contracts with Plan Providers

How Plan Providers are paid

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

Financial liability

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

Termination of a Plan Provider's contract

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

under "Getting a Referral" in this "How to Obtain Services" section.

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

Visiting Other Regions

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

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

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

Your ID Card

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

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

Getting Assistance

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your personal Plan Physician or with other Plan Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Member Services

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 weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m. (except holidays) toll free at 1-800-464-4000 or 1-800-777-1370 (TTY for the deaf, hard of hearing, or speech impaired). For your convenience, you can also contact us through our Web site at **kp.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 "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section or with any issues as described in the "Dispute Resolution" section.

Interpreter services

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

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:

- 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 (please refer to *Your Guidebook* for Urgent Care locations in your area)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services Department (refer to *Your Guidebook* for locations in your area)

Plan Hospitals and Plan Medical Offices

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

Northern California Region Plan Hospitals and Plan Medical Offices

Alameda

- Medical Offices: 2417 Central Ave.

Antioch

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

Campbell

- Medical Offices: 220 E. Hacienda Ave.

Clovis

- Medical Offices: 2071 Herndon Ave.

Daly City

- Medical Offices: 395 Hickey Blvd.

Davis

- Medical Offices: 1955 Cowell Blvd.

Elk Grove

- Medical Offices: 9201 Big Horn Blvd.

Fairfield

- Medical Offices: 1550 Gateway Blvd.

Folsom

- Medical Offices: 2155 Iron Point Rd.

Fremont

- Hospital and Medical Offices: 39400 Paseo Padre Pkwy.

Fresno

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

Gilroy

- Medical Offices: 7520 Arroyo Circle

Hayward

- Hospital and Medical Offices: 27400 Hesperian Blvd.

Lincoln

- Medical Offices: 1900 Dresden Dr.

Livermore

- Medical Offices: 3000 Las Positas Rd.

Manteca

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

Martinez

- Medical Offices: 200 Muir Rd.

Milpitas

- Medical Offices: 770 E. Calaveras Blvd.

Modesto

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

Mountain View

- Medical Offices: 555 Castro St.

Napa

- Medical Offices: 3285 Claremont Way

Novato

- Medical Offices: 97 San Marin Dr.

Oakhurst

- Medical Offices: 40595 Westlake Dr.

Oakland

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

Petaluma

- Medical Offices: 3900 Lakeville Hwy.

Pinole

- Medical Offices: 1301 Pinole Valley Rd.

Pleasanton

- Medical Offices: 7601 Stoneridge Dr.

Rancho Cordova

- Medical Offices: 10725 International Dr.

Redwood City

- Hospital and Medical Offices: 1150 Veterans Blvd.

Richmond

- Hospital and Medical Offices: 901 Nevin Ave.

Rohnert Park

- Medical Offices: 5900 State Farm Dr.

Roseville

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

Sacramento

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

San Bruno

- Medical Offices: 901 El Camino Real

San Francisco

- Hospital and Medical Offices: 2425 Geary Blvd.

San Jose

- Hospital and Medical Offices: 250 Hospital Pkwy.

San Rafael

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

Santa Clara

- Hospital and Medical Offices: 700 Lawrence Expwy.

Santa Rosa

- Hospital and Medical Offices: 401 Bicentennial Way

Selma

- Medical Offices: 2651 Highland Ave.

South San Francisco

- Hospital and Medical Offices: 1200 El Camino Real

Stockton

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

Tracy

- Medical Offices: 2185 W. Grant Line Rd.

Turlock

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

Union City

- Medical Offices: 3553 Whipple Rd.

Vacaville

- Hospital and Medical Offices: 1 Quality Dr.

Vallejo

- Hospital and Medical Offices: 975 Sereno Dr.

Walnut Creek

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

**Southern California Region Plan
Hospitals and Plan Medical Offices**

Aliso Viejo

- Medical Offices: 24502 Pacific Park Dr.

Anaheim

- Hospital and Medical Offices: 441 N. Lakeview Ave.
- Medical Offices: 411 N. Lakeview Ave., 5475 E. La Palma Ave., and 1188 N. Euclid St.

Bakersfield

- Hospital: 2615 Chester Ave. (San Joaquin Community Hospital)
- Medical Offices: 1200 Discovery Dr., 3501 Stockdale Hwy., 3700 Mall View Rd., 4801 Coffee Rd., and 8800 Ming Ave.

Baldwin Park

- Hospital and Medical Offices: 1011 Baldwin Park Blvd.

Bellflower

- Medical Offices: 9400 E. Rosecrans Ave.

Bonita

- Medical Offices: 3955 Bonita Rd.

Brea

- Medical Offices: 1900 E. Lambert Rd.

Camarillo

- Medical Offices: 2620 E. Las Posas Rd.

Carlsbad

- Medical Offices: 6860 Avenida Encinas

Chino

- Medical Offices: 11911 Central Ave.

Claremont

- Medical Offices: 250 W. San Jose St.

Colton

- Medical Offices: 789 S. Cooley Dr.

Corona

- Medical Offices: 2055 Kellogg Ave.

Cudahy

- Medical Offices: 7825 Atlantic Ave.

Culver City

- Medical Offices: 5620 Mesmer Ave.

Diamond Bar

- Medical Offices: 1336 Bridge Gate Dr.

Downey

- Hospital: 9333 E. Imperial Hwy.
- Medical Offices: 9449 E. Imperial Hwy.

El Cajon

- Medical Offices: 1630 E. Main St.

Escondido

- Hospital: 555 E. Valley Pkwy. (Palomar Medical Center)
- Medical Offices: 732 N. Broadway St.

Fontana

- Hospital and Medical Offices: 9961 Sierra Ave.

Garden Grove

- Medical Offices: 12100 Euclid St.

Gardena

- Medical Offices: 15446 S. Western Ave.

Glendale

- Medical Offices: 444 W. Glenoaks Blvd.

Harbor City

- Hospital and Medical Offices: 25825 S. Vermont Ave.

Huntington Beach

- Medical Offices: 18081 Beach Blvd.

Indio

- Hospital: 47111 Monroe St. (John F. Kennedy Memorial Hospital)
- Medical Offices: 81-719 Doctor Carreon Blvd.

Inglewood

- Medical Offices: 110 N. La Brea Ave.

Irvine

- Hospital and Medical Offices: 6640 Alton Pkwy.
- Medical Offices: 6 Willard St.

Joshua Tree

- Hospital: 6601 White Feather Rd. (Hi-Desert Medical Center)
- Please refer to *Your Guidebook* for other Plan Providers in the Yucca Valley–Twentynine Palms area

La Mesa

- Medical Offices: 8080 Parkway Dr. and 3875 Avocado Blvd.

La Palma

- Medical Offices: 5 Centerpointe Dr.

Lancaster

- Hospitals: 1600 W. Avenue J (Antelope Valley Hospital) and 43830 N. 10th St. W. (Lancaster Community Hospital)
- Medical Offices: 43112 N. 15th St. W.

Long Beach

- Medical Offices: 3900 E. Pacific Coast Hwy.

Los Angeles

- Hospitals and Medical Offices: 1526 N. Edgemont St. and 6041 Cadillac Ave.
- Medical Offices: 5119 E. Pomona Blvd. and 12001 W. Washington Blvd.

Lynwood

- Medical Offices: 3840 Martin Luther King Jr. Blvd.

Mission Hills

- Medical Offices: 11001 Sepulveda Blvd.

Mission Viejo

- Medical Offices: 23781 Maquina Ave.

Montebello

- Medical Offices: 1550 Town Center Dr.

Moreno Valley

- Hospital: 27300 Iris Ave. (Moreno Valley Community Hospital)
- Medical Offices: 12815 Heacock St.

Murrieta

- Hospital: 25500 Medical Center Dr. (Rancho Springs Medical Center)

Oceanside

- Medical Offices: 3609 Ocean Ranch Blvd.

Ontario

- Medical Offices: 2295 S. Vineyard Ave.

Oxnard

- Medical Offices: 2200 E. Gonzales Rd.

Palm Desert

- Medical Offices: 75-036 Gerald Ford Dr.

Palm Springs

- Hospital: 1150 N. Indian Canyon Dr. (Desert Regional Medical Center)
- Medical Offices: 1100 N. Palm Canyon Dr.

Palmdale

- Medical Offices: 4502 E. Avenue S

Panorama City

- Hospital and Medical Offices: 13652 Cantara St.

Pasadena

- Medical Offices: 3280 E. Foothill Blvd.

Rancho Cucamonga

- Medical Offices: 10850 Arrow Rte.

Redlands

- Medical Offices: 1301 California St.

Riverside

- Hospital and Medical Offices: 10800 Magnolia Ave.

San Bernardino

- Medical Offices: 1717 Date Pl.

San Diego

- Hospital and Medical Offices: 4647 Zion Ave.

- Medical Offices: 3250 Wing St., 4405 Vandever Ave., 4650 Palm Ave., 7060 Clairemont Mesa Blvd., and 11939 Rancho Bernardo Rd.

San Dimas

- Medical Offices: 1255 W. Arrow Hwy.

San Juan Capistrano

- Medical Offices: 30400 Camino Capistrano

San Marcos

- Medical Offices: 400 Craven Rd.

Santa Ana

- Medical Offices: 3401 S. Harbor Blvd. and 1900 E. 4th St.

Santa Clarita

- Medical Offices: 27107 Tourney Rd.

Simi Valley

- Medical Offices: 3900 Alamo St.

Temecula

- Medical Offices: 27309 Madison Ave.

Thousand Oaks

- Medical Offices: 365 E. Hillcrest Dr. and 145 Hodencamp Rd.

Torrance

- Medical Offices: 20790 Madrona Ave.

Upland

- Medical Offices: 1183 E. Foothill Blvd.

Ventura

- Hospital: 147 N. Brent St. (Community Memorial Hospital of San Buenaventura)
- Medical Offices: 888 S. Hill Rd.

Victorville

- Medical Offices: 14011 Park Ave.

West Covina

- Medical Offices: 1249 Sunset Ave.

Whittier

- Medical Offices: 12470 Whittier Blvd.

Wildomar

- Hospital: 36485 Inland Valley Dr. (Inland Valley Medical Center)
- Medical Offices: 36450 Inland Valley Dr.

Woodland Hills

- Hospital and Medical Offices: 5601 De Soto Ave.

- Medical Offices: 21263 Erwin St.

Yorba Linda

- Medical Offices: 22550 E. Savi Ranch Pkwy.

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.

Your Guidebook to Kaiser Permanente Services (Your Guidebook)

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

Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers

This "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section explains how to obtain covered Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care from

Non-Plan Providers. We do not cover the Non-Plan Provider care discussed in this section unless it meets both of the following requirements:

- This "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section says that we cover the care
- The care would be covered under the "Benefits and Cost Sharing" section (subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section) if you received the care from a Plan Provider

For example, we will not cover non-Plan Skilled Nursing Facility care as part of authorized Post-Stabilization Care unless both of the following are true:

- This "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section says that we cover the care (we authorize the care and the care meets the definition of "Post-Stabilization Care")
- The care would be covered under "Skilled Nursing Facility Care" in the "Benefits and Cost Sharing" section (subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section) if you received the care from a Plan Skilled Nursing Facility inside our Service Area

Prior Authorization

You do not need to get prior authorization from us to get Emergency Care or Out-of-Area Urgent Care from Non-Plan Providers. However, you must get prior authorization from us for Post-Stabilization Care from Non-Plan Providers (prior authorization means that we must approve the Services in advance for the Services to be covered).

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 anywhere in the world.

An Emergency Medical Condition is: (1) 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 serious jeopardy to your health or body functions or organs, or (2) active labor when there isn't enough time for safe transfer to a Plan Hospital (or designated hospital) before delivery or

if transfer poses a threat to your (or your unborn child's) health and safety.

For ease and continuity of care, we encourage you to go to a Plan Hospital Emergency Department listed in *Your Guidebook* if you are inside our Service Area, but only if it is reasonable to do so, considering your condition or symptoms.

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that this condition is Clinically Stable. We cover Post-Stabilization Care from a Non-Plan Provider, including inpatient care at a Non-Plan Hospital, only if we provide prior authorization for the care.

To request authorization to receive Post-Stabilization Care from a Non-Plan Provider, you must call us toll free at **1-800-225-8883** (TTY users call 711) or the notification telephone number on your Kaiser Permanente ID card *before* you receive the care if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible). After we are notified, we will discuss your condition with the Non-Plan Provider. If we decide that you require Post-Stabilization Care and that this care would be covered if you received it from a Plan Provider, we will authorize your care from the Non-Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated Non-Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered.

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

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

Out-of-Area Urgent Care

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

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

Services Not Covered Under this "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" Section

The following Services are not covered under this "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section (instead, refer to the "Benefits and Cost Sharing" section):

- Services that are not Emergency Care, Post-Stabilization Care, or Out-of-Area Urgent Care, even if those services are related to your Emergency Medical Condition
- Emergency Care, Post-Stabilization Care, and Urgent Care from Plan Providers

Payment and Reimbursement

If you receive Emergency Care, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non-Plan Provider, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us. Also, you may be required to pay and file a claim for any Services prescribed by a Non-Plan Provider as part of covered Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care even if you receive the Services from a Plan Provider, such as a Plan Pharmacy.

How to file a claim

To file a claim for payment or reimbursement, this is what you need to do:

- As soon as possible, send us a completed claim form. You can get a claim form by visiting our Web site at **kp.org** or by calling our Member Service Call Center toll free at 1-800-464-4000 or 1-800-390-3510 (TTY users call 1-800-777-1370). 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 include any bills and receipts from the Non-Plan Provider with your claim form
- To request that we pay a Non-Plan Provider for Services, you must include any bills from the Non-Plan Provider with your claim form. If the Non-Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If you later receive any bills from the Non-Plan Provider for covered Services (other than bills for your Cost Sharing amount), please call our Member Service Call Center toll free at 1-800-390-3510 for assistance
- The completed claim form and any bills or receipts must be mailed to the following address as soon as possible after receiving the care:

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

If we ask you to provide information or complete a document in connection with your claim, you must send it to our Claims Department at the address above. For example, we might request that you provide completed claim forms, consents for the release of medical records, assignments, claims for any other benefits to which you may be entitled, or original travel tickets to validate your claim.

We will respond to your claim as follows:

- If your Group must comply with Employee Retirement Income Security Act (ERISA), we will send our written decision within 30 calendar days after we receive the claim unless we request additional information from you or the Non-Plan Provider. If we request additional information, we will send our written decision no later than 15 calendar days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in the

letter, we will make our decision based on the information we have

- If your Group is not subject to ERISA, we will send our written decision within 45 business days after we receive the claim unless we request additional information from you or the Non-Plan Provider. If we request additional information, we will send our written decision no later than 45 business days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in the letter, we will make our decision based on the information we have

If our decision is not fully in your favor, we will tell you the reasons and how to file a grievance as described under "Grievances" in the "Dispute Resolution" section.

Cost Sharing

The Cost Sharing for Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care from a Non-Plan Provider is the Cost Sharing required for Services provided by a Plan Provider as described in the "Benefits and Cost Sharing" section. We will reduce any payment we make to you or the Non-Plan Provider by applicable Cost Sharing.

Benefits and Cost Sharing

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

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except where specifically noted to the contrary in the sections listed below for the following Services:
 - ◆ emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
 - ◆ Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section
- You receive the Services from Plan Providers inside our Service Area, except where specifically noted to the contrary in the sections listed below for the following Services:

- ◆ authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- ◆ emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
- ◆ Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section
- ◆ hospice care as described under "Hospice Care" in this "Benefits and Cost Sharing" section

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

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

Cost Sharing

At the time you receive covered Services, you must pay the Cost Sharing in effect on that date, except as follows:

- If you are receiving covered inpatient hospital or Skilled Nursing Facility Services on the effective date of this *Evidence of Coverage*, you pay the Cost Sharing in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Sharing in effect on the date you receive the Services
- For items ordered in advance, you pay the Cost Sharing in effect on the order date (although we will

not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all the information they need to fill the prescription

- Before starting or continuing a course of infertility Services, you may be required to pay initial and subsequent deposits toward your Cost Sharing for some or all of the entire course of Services, along with any past-due infertility-related Cost Sharing. Any unused portion of your deposit will be returned to you. When a deposit is not required, before you can schedule an infertility procedure, you must pay the Cost Sharing for the procedure, along with any past-due infertility-related Cost Sharing
- If you receive more than one Service from a provider, or Services from more than one provider, you may be required to pay separate Cost Sharing amounts for each Service and each provider. For example, if you receive Services from two specialists in one visit, you may have to pay the Cost Sharing for two specialist visits. Similarly, if your physician performs a procedure immediately after a consultation, you may have to pay separate Cost Sharing amounts for the consultation visit and for the procedure. If you have questions about Cost Sharing, please contact our Member Service Call Center
- In some cases, we may agree to bill you for your Cost Sharing amounts

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

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service is described in this "Benefits and Cost Sharing" section.

Annual out-of-pocket maximum

There is a limit to the total amount of Cost Sharing you must pay under this *Evidence of Coverage* in a calendar year for all of the covered Services listed below that you receive in the same calendar year, except that Cost Sharing you pay for Services that are provided in connection with genital surgery or mastectomy covered under "Transgender Surgery" in this "Benefits and Cost Sharing" section, do not apply to the annual out-of-pocket maximum. The limit is one of the following amounts:

- **\$1,500** per calendar year for self-only enrollment (a Family of one Member)

- **\$1,500** per calendar year for any one Member in a Family of two or more Members
- **\$3,000** per calendar year for an entire Family of two or more Members

If you are a Member in a Family of two or more Members, you reach the annual out-of-pocket maximum either when you meet the maximum for any one Member, or when your Family reaches the Family maximum. For example, suppose you have reached the **\$1,500** maximum. For Services subject to the maximum, you will not pay any more Cost Sharing during the rest of the calendar year, but every other Member in your Family must continue to pay Cost Sharing during the calendar year until your Family reaches the **\$3,000** maximum.

Payments that count toward the maximum. The Copayments and Coinsurance you pay for the following Services apply toward the annual out-of-pocket maximum except that Copayments and Coinsurance you pay for Services covered under "Infertility Services" in this "Benefits and Cost Sharing" section do not apply to the annual out-of-pocket maximum except that Copayments and Coinsurance you pay for Services that are provided in connection with genital surgery or mastectomy covered under "Transgender Surgery" in this "Benefits and Cost Sharing" section do not apply to the annual out-of-pocket maximum:

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

Keeping track of the maximum. When you pay Cost Sharing that applies toward the annual out-of-pocket maximum, 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 Cost Sharing for Services subject to the annual out-of-pocket maximum through the end of the calendar year.

Preventive Care Services

We cover a variety of preventive care Services, which are Services to help keep you healthy or to prevent illness. This "Preventive Care Services" section lists examples of preventive care Services, but it does not explain coverage. These preventive care Services remain subject to the Cost Sharing and all other coverage requirements described in this "Benefits and Cost Sharing" section and all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section:

- Family planning visits
- Flexible sigmoidoscopies
- Health Education
- Vaccines administered in a Plan Medical Office
- Mammograms
- Routine preventive retinal photography screenings
- Routine preventive physical exams, including well-woman visits, eye exams for refraction, and hearing exams
- Scheduled prenatal visits and first postpartum visit
- Tuberculosis tests
- Well-child preventive care visits (0–23 months)
- The following laboratory tests:
 - ◆ cervical cancer screening including screening for human papillomavirus (HPV)
 - ◆ cholesterol tests (lipid panel and profile)
 - ◆ diabetes screening (fasting blood glucose tests)
 - ◆ fecal occult blood tests
 - ◆ HIV tests
 - ◆ prostate specific antigen tests
 - ◆ sexually transmitted disease (STD) tests

Outpatient Care

We cover the following outpatient care for preventive medicine, diagnosis, and treatment subject to the Cost Sharing indicated:

- Routine preventive care:
 - ◆ physical exams, including well-woman visits: **a \$15 Copayment per visit**
 - ◆ well-child visits for Members through age 23 months: **no charge**
 - ◆ family planning visits for counseling, or to obtain emergency contraceptive pills, injectable contraceptives, internally implanted time-release contraceptives, or intrauterine devices (IUDs): **a \$15 Copayment per visit**
 - ◆ after confirmation of pregnancy, the normal series of regularly scheduled preventive care prenatal visits and the first postpartum visit: **no charge**
 - ◆ eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses: **a \$15 Copayment per visit**
 - ◆ hearing tests to determine the need for hearing correction: **a \$15 Copayment per visit**
 - ◆ vaccines (immunizations) administered to you in a Plan Medical Office: **no charge**
 - ◆ flexible sigmoidoscopies: **a \$15 Copayment per visit**
- Primary and specialty care visits: **a \$15 Copayment per visit**
- Allergy injection visits: **a \$5 Copayment per visit**
- Up to two Medically Necessary contact lenses, fitting, and dispensing per eye every 12 months (including lenses we covered under any other evidence of coverage offered by your Group) to treat aniridia (missing iris): **no charge**
- Up to six Medically Necessary aphakic contact lenses, fitting, and dispensing per eye per calendar year (including lenses we covered under any other evidence of coverage offered by your Group) to treat aphakia (absence of the crystalline lens of the eye) for Members through age 9: **no charge**
- Outpatient surgery and other outpatient procedures: **a \$15 Copayment per procedure**
- Voluntary termination of pregnancy: **a \$15 Copayment per procedure**
- Physical, occupational, and speech therapy: **a \$15 Copayment per visit**
- Physical, occupational, and speech therapy provided in our organized, multidisciplinary rehabilitation day-treatment program: **a \$15 Copayment per day**

- Urgent Care visits: **a \$15 Copayment per visit**
- Emergency Department visits: **a \$50 Copayment per visit**. The Emergency Department Copayment does not apply if you are admitted directly to the hospital as an inpatient, or if you are admitted for observation and are then admitted directly to the hospital as an inpatient (for inpatient care, please refer to "Hospital Inpatient Care" in this "Benefits and Cost Sharing" section). The Emergency Department Copayment does apply if you are admitted for observation but are not admitted as an inpatient
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician: **no charge**
- Blood, blood products, and their administration: **no charge**
- Administered drugs (drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials) prescribed in accord with our drug formulary guidelines, if administration or observation by medical personnel is required and they are administered to you in a Plan Medical Office or during home visits: **no charge**
- Some types of outpatient visits may be available as group appointments, which we cover at **a \$7 Copayment per visit**

Services not covered under this "Outpatient Care" section

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

- 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

- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Transgender Surgery
- Transplant Services

Hospital Inpatient Care

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

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

Services not covered under this "Hospital Inpatient Care" section

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

- Chemical Dependency Services
- Dental Services for Radiation Treatment and Dental Anesthesia
- Dialysis Care
- Hospice Care
- Infertility Services
- Mental Health Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Skilled Nursing Facility Care
- Transgender Surgery
- Transplant Services

Ambulance Services

Emergency

When you have an Emergency Medical Condition, we cover emergency Services of a licensed ambulance anywhere in the world at **no charge**. In accord with the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section, 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 and psychiatric transport van Services at **no charge** if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to or from covered Services.

Ambulance Services exclusion

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

Chemical Dependency Services

Inpatient detoxification

We cover hospitalization at a **\$250 Copayment 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 chemical dependency care

We cover the following Services for treatment of chemical dependency:

- Day-treatment programs
- Intensive outpatient programs
- Individual and group chemical dependency counseling visits
- Visits for the purpose of medical treatment for withdrawal symptoms

You pay the following for these covered Services:

- Individual visits: **a \$15 Copayment per visit**
- Group visits: **a \$5 Copayment per visit**

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

Transitional residential recovery Services

We cover chemical dependency treatment in a nonmedical transitional residential recovery setting approved in writing by the Medical Group. We cover these Services at a **\$100 Copayment per admission**. These settings provide counseling and support services in a structured environment.

Services not covered under this "Chemical Dependency Services" section

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

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

Chemical dependency Services exclusion

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

Dental Services for Radiation Treatment and Dental Anesthesia

Dental Services for radiation treatment

We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck at a **\$15 Copayment per visit** if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental anesthesia

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

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

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

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

Services not covered under this "Dental Services for Radiation Treatment and Dental Anesthesia" section

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

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

Dialysis Care

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

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

After the referral to a dialysis facility, we cover equipment, training, and medical supplies required for home dialysis.

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

- Inpatient dialysis care: a **\$250 Copayment per admission**
- One routine office visit per month with the multidisciplinary nephrology team: **no charge**
- All other office visits: a **\$15 Copayment per visit**
- Hemodialysis treatment: a **\$15 Copayment per visit**

Services not covered under this "Dialysis Care" section

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

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

Durable Medical Equipment for Home Use

Inside our Service Area, we cover durable medical equipment for use in your home (or another location used as your home) in accord with our durable medical equipment formulary guidelines. Durable medical

equipment for home use is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. Covered durable medical equipment (including repair or replacement of covered equipment, unless due to loss or misuse) is provided at **no charge**. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.

Durable medical equipment for diabetes

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

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

Outside the Service Area

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

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

About our durable medical equipment formulary

Our durable medical equipment formulary includes the list of durable medical equipment that has been approved by our Durable Medical Equipment Formulary Executive Committee for our Members. Our durable medical

equipment formulary was developed by a multidisciplinary clinical and operational work group with review and input from Plan Physicians and medical professionals with durable medical equipment expertise (for example: physical, respiratory, and enterostomal therapists and home health). A multidisciplinary Durable Medical Equipment Formulary Executive Committee is responsible for reviewing and revising the durable medical equipment formulary. Our durable medical equipment formulary is periodically updated to keep pace with changes in medical technology and clinical practice. To find out whether a particular item is included in our durable medical equipment formulary, please call our Member Service Call Center.

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

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

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

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

Durable medical equipment for home use exclusions

- Comfort, convenience, or luxury equipment or features
- 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 healthy living (health education) programs to help you take an active role in protecting and improving your health, including programs for tobacco cessation, stress management, and chronic conditions (such as diabetes and asthma). We cover individual office visits at a **\$15 Copayment per visit**. We provide all other covered Services at **no charge**. You can also participate in programs that we don't cover, which may require that you pay a fee.

For more information about our healthy living programs, please contact your local Health Education Department or our Member Service Call Center, or go to our Web site at **kp.org**. *Your Guidebook* also includes information about our healthy living programs.

Hearing Services

We cover the following:

- Hearing tests to determine the appropriate hearing aid: **no charge**
- A **\$1,000 Allowance** for each ear toward the purchase price of a hearing aid every 36 months when prescribed by a Plan Physician or by a Plan Provider who is an 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 provided an Allowance toward (or otherwise covered) a hearing aid 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.

Services not covered under this "Hearing Services" section

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

- Hearing tests to determine the need for hearing correction (refer to "Outpatient Care")

- Services related to the ear or hearing other than those related to hearing aids described in this section (refer to the applicable heading in this "Benefits and Cost Sharing" section)
- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Hearing Services exclusions

- 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 home health care at **no charge** only if all of the following are true:

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

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

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

Note: If a visit by a nurse, medical social worker, or physical, occupational, or speech therapist lasts longer than two hours, then each additional increment of two hours counts as a separate visit. If a visit by a home health aide lasts longer than four hours, then each additional increment of four hours counts as a separate

visit. For example, if a nurse comes to your home for three hours and then leaves, that counts as two visits. Also, each person providing Services counts toward these visit limits. For example, if a home health aide and a nurse are both at your home during the same two hours, that counts as two visits.

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

- Dialysis Care
- Durable Medical Equipment for Home Use
- Ostomy and Urological Supplies
- Outpatient Prescription Drugs, Supplies, and Supplements
- 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:

- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside our Service Area or inside California but within 15 miles or 30 minutes from our Service Area (including a friend's or relative's home even if you live there temporarily)

- The Services are provided by a licensed hospice agency that is a Plan Provider
- The Services are necessary for the palliation and management of your terminal illness and related conditions

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

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, or speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from Plan Pharmacies. Certain drugs are limited to a maximum 30-day supply in any 30-day period (please call our Member Service 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

Infertility Services

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

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

Services not covered under this "Infertility Services" section

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

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

Infertility Services exclusions

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

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when both of the following requirements have been met:

- The Services are for the diagnosis or treatment of mental disorders
- The Services are provided by a Plan Physician or other Plan Provider who is a licensed health care professional acting within the scope of his or her license

A mental disorder is a mental health condition as identified in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

Mental Disorders include the Severe Mental Illness of a person of any age and the Serious Emotional Disturbance of a Child:

- Severe Mental Illness means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

- A Serious Emotional Disturbance of a child under age 18 means mental disorders as identified in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, 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 (1) the child is at risk of removal from the home or has already been removed from the home, or (2) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
 - ♦ the child displays psychotic features, or risk of suicide or violence due to a mental disorder
 - ♦ the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

Outpatient mental health Services

We cover:

- Individual and group visits for diagnostic evaluation and psychiatric treatment
- Psychological testing when necessary to evaluate a mental disorder
- Visits for the purpose of monitoring drug therapy

You pay the following for these covered Services:

- Individual visits: **a \$15 Copayment per visit**
- Group visits: **a \$7 Copayment per visit**

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

Inpatient psychiatric hospitalization and intensive psychiatric treatment programs

Inpatient psychiatric hospitalization. We cover inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and Services of Plan Physicians and other Plan Providers who are

mental health professionals. We cover these Services at a **\$250 Copayment per admission**.

Intensive psychiatric treatment programs. We cover at **no charge** the following intensive psychiatric treatment programs in a Plan Facility:

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

Services not covered under this "Mental Health Services" section

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

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

Ostomy and Urological Supplies

Inside our Service Area, we cover ostomy and urological supplies prescribed in accord with our soft goods formulary guidelines at **no charge**. We select the vendor, and coverage is limited to the standard supply that adequately meets your medical needs.

About our soft goods formulary

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

described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

Ostomy and urological supplies exclusion

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Special Procedures

We cover the following Services at the Cost Sharing indicated only when prescribed as part of care covered under other parts of this "Benefits and Cost Sharing" section or when prescribed by a psychiatrist who is not a Plan Physician to treat mental health conditions unless a Plan Physician determines that the Services are not Medically Necessary:

- Diagnostic and therapeutic imaging, such as X-rays, mammograms, and ultrasound: **no charge** except that certain imaging procedures are covered at a **\$15 Copayment 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
- MRI, CT, and PET: **no charge**
- Nuclear medicine: **no charge**
- Laboratory tests (including tests for specific genetic disorders for which genetic counseling is available):
 - ◆ laboratory tests to monitor the effectiveness of dialysis: **no charge**
 - ◆ fecal occult blood tests: **no charge**
 - ◆ cervical cancer screening—including screening for human papillomavirus (HPV), prostate specific antigen tests, cholesterol tests (lipid panel and profile), diabetes screening (fasting blood glucose tests), sexually transmitted disease (STD) tests, and HIV tests: **no charge**
 - ◆ laboratory tests prescribed by a psychiatrist who is not a Plan Physician to treat mental health conditions: **no charge**
 - ◆ all other laboratory tests: **no charge**
- Routine preventive retinal photography screenings: **no charge**
- All other diagnostic procedures provided by Plan Providers who are not physicians (such as EKGs and EEGs): **no charge** except that certain diagnostic procedures are covered at a **\$15 Copayment 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. We also we cover electrocardiograms at the applicable Cost Sharing if they are prescribed by a psychiatrist who is not a Plan Physician to treat mental health conditions unless a Plan Physician determines that they are not Medically Necessary

- Radiation therapy: **no charge**
- Ultraviolet light treatments: **no charge**

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

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

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

Outpatient Prescription Drugs, Supplies, and Supplements

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

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

described under "Payment and Reimbursement" in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non–Plan Providers" section)

- Items prescribed by psychiatrists who are not Plan Physicians if the drug is for mental health care (this coverage does not include drugs to treat sexual dysfunction disorders)

How to obtain covered items

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

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

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

Outpatient drugs, supplies, and supplements

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

- Drugs for which a prescription is required by law. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary. Note: Certain tobacco-cessation drugs are covered only if you participate in a behavioral intervention program approved by the Medical Group
- Diaphragms, cervical caps, and oral contraceptives (including emergency contraceptive pills)
- Disposable needles and syringes needed for injecting covered drugs
- Inhaler spacers needed to inhale covered drugs

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

- Generic items:
 - ◆ a **\$5 Copayment** for up to a 30-day supply, a **\$10 Copayment** for a 31- to 60-day supply, or a **\$15 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
 - ◆ a **\$5 Copayment** for up to a 30-day supply or a **\$10 Copayment** for a 31- to 100-day supply through our mail-order service
 - ◆ drugs prescribed for the treatment of sexual dysfunction disorders: **50% Coinsurance** for up to a 100-day supply at a Plan Pharmacy or through our mail-order service
 - ◆ drugs prescribed for the treatment of infertility: **50% Coinsurance** for up to a 100-day supply at a Plan Pharmacy or through our mail-order service
- Brand-name items and compounded products:
 - ◆ a **\$20 Copayment** for up to a 30-day supply, a **\$40 Copayment** for a 31- to 60-day supply, or a **\$60 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
 - ◆ a **\$20 Copayment** for up to a 30-day supply or a **\$40 Copayment** for a 31- to 100-day supply through our mail-order service
 - ◆ drugs prescribed for the treatment of sexual dysfunction disorders: **50% Coinsurance** for up to a 100-day supply at a Plan Pharmacy or through our mail-order service
 - ◆ drugs prescribed for the treatment of infertility: **50% Coinsurance** for up to a 100-day supply at a Plan Pharmacy or through our mail-order service
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria) and elemental dietary enteral formula when used as a primary therapy for regional enteritis: **no charge** for up to a 30-day supply
- Emergency contraceptive pills: **no charge**
- Hematopoietic agents for dialysis: **no charge** for up to a 30-day supply
- Continuity drugs (if this *Evidence of Coverage* is amended to exclude a drug that we have been covering and providing to you under this *Evidence of Coverage*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration): **50% Coinsurance** for up to a 30-day supply in a 30-day period

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

Certain intravenous drugs, supplies, and supplements

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

Diabetes urine-testing supplies and insulin-administration devices

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

We cover the following insulin-administration devices at a **\$5 Copayment** for up to a 100-day supply: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear).

Day supply limit

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

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

About our drug formulary

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

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

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

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

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

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

Prosthetic and Orthotic Devices

We cover the devices specified in this "Prosthetic and Orthotic Devices" section 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. Coverage is 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 (unless due to loss or misuse), and Services to determine whether you need a prosthetic or orthotic device. If we do not cover the device, we will 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, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints.

External devices

We cover the following external prosthetic and orthotic devices (including repair or replacement of covered devices, unless due to loss or misuse) at **no charge**:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres required to hold a prosthesis every 12 months
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist

- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect
- Other covered prosthetic and orthotic devices:
 - ◆ prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity
 - ◆ rigid and semi-rigid orthotic devices required to support or correct a defective body part
 - ◆ covered special footwear when custom made for foot disfigurement due to disease, injury, or developmental disability

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

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

- Contact lenses to treat aniridia or aphakia (refer to "Outpatient Care")
- Hearing aids other than internally implanted devices described in this section (refer to "Hearing Services")

Prosthetic and orthotic devices exclusions

- Dental appliances
- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Except as otherwise described above in this "Prosthetic and Orthotic Devices" section, nonrigid supplies, such as elastic stockings and wigs
- Comfort, convenience, or luxury equipment or features
- Shoes or arch supports, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications 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: **a \$15 Copayment per visit**
- Outpatient surgery: **a \$15 Copayment per procedure**
- Hospital inpatient care (including room and board, drugs, and Plan Physician Services): **a \$250 Copayment per admission**

Services not covered under this "Reconstructive Surgery" section

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

- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Transgender surgery (refer to "Transgender Surgery")

Reconstructive surgery exclusions

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

Services Associated with Clinical Trials

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

- You are diagnosed with cancer
- You are accepted into a phase I, II, III, or IV clinical trial for cancer
- Your treating Plan Physician, or your treating Non-Plan Physician if the Medical Group authorizes a written referral to the Non-Plan Physician for treatment of cancer (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services"

section), recommends participation in the clinical trial after determining that it has a meaningful potential to benefit you

- The Services would be covered under this *Evidence of Coverage* if they were not provided in connection with a clinical trial
- The clinical trial has a therapeutic intent, and its end points are not defined exclusively to test toxicity
- The clinical trial involves a drug that is exempt under federal regulations from a new drug application, or the clinical trial is approved by: one of the National Institutes of Health, the federal Food and Drug Administration (in the form of an investigational new drug application), the U.S. Department of Defense, or the U.S. Department of Veterans Affairs

For covered Services related to a clinical trial, you will pay the **Cost Sharing you would pay if the Services were not related to a clinical trial.**

Services associated with clinical trials exclusions

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

Skilled Nursing Facility Care

Inside our Service Area, we cover at **no charge** up to 100 days per calendar year (including any days we covered under any other evidence of coverage offered by your Group) of skilled inpatient Services in a Plan Skilled Nursing Facility. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

We cover the following Services:

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

- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Blood, blood products, and their administration
- Medical supplies
- Physical, occupational, and speech therapy
- Respiratory therapy

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

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

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

Transgender Surgery

Up to a \$75,000 lifetime maximum, we cover genital surgery and mastectomy if Medical Group authorizes the surgery in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section. The lifetime maximum is calculated by adding up the Charges for transgender surgical Services we cover for you, including any related travel and lodging preauthorized in accord with our travel and lodging guidelines, less any Cost Sharing that you paid for those Services.

You pay the following for these covered transgender surgical Services:

- Office visits: **a \$15 Copayment per visit**
- Outpatient surgery and other outpatient procedures: **a \$15 Copayment per procedure**
- Hospital inpatient care (including room and board, drugs, and Plan Physician Services): **a \$250 Copayment per admission**

Services not covered under this "Transgender Surgery" section

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

- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")

- Psychological counseling (refer to "Mental Health Services")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

Transgender surgery exclusion

- Surgery or other Services that are intended primarily to change or maintain your appearance, voice, or other characteristics, except for the covered transgender surgery Services listed in this "Transgender Surgery" section

Transplant Services

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

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

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

For covered transplant Services that you receive, you will pay the **Cost Sharing you would pay if the Services were not related to a transplant.**

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

Services not covered under this "Transplant Services" section

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

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

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The Services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this *Evidence of Coverage*. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the "Benefits and Cost Sharing" section.

Certain exams and Services

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

Chiropractic Services

Chiropractic Services and the Services of a chiropractor.

Conception by artificial means

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

Cosmetic Services

Services that are intended primarily to change or maintain your appearance, except for Services covered under "Reconstructive Surgery," "Transgender Surgery,"

and the following prosthetic devices covered under "Prosthetic and Orthotic Devices" in the "Benefits and Cost Sharing" section: prostheses needed after a mastectomy and prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect.

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 the "Benefits and Cost Sharing" section.

Dental care

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

Disposable supplies

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

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

Experimental or investigational Services

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

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

This exclusion does not apply to any of the following:

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

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

Eye surgery, eyeglasses and contact lenses, and contact lens eye examinations

- Services related to eye surgery or orthokeratologic Services for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism
- Eyeglass lenses and frames
- Contact lenses, including fitting and dispensing
- Eye examinations for the purpose of obtaining or maintaining contact lenses
- Low vision devices

This exclusion does not apply to contact lenses to treat aniridia or aphakia covered under "Outpatient Care" in the "Benefits and Cost Sharing" section.

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 the "Benefits and Cost Sharing" section.

Oral nutrition

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

This exclusion does not apply to any of the following:

- Amino acid–modified products and elemental dietary enteral formula covered under "Outpatient

Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section

- Enteral formula covered under "Prosthetic and Orthotic Devices" in the "Benefits and Cost Sharing" section

Residential care

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

Routine foot care Services

Routine foot care Services that are not Medically Necessary.

Services not approved by the federal Food and Drug Administration

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

This exclusion does not apply to any of the following:

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

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

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services we would otherwise cover to treat complications of the noncovered Service.

Speech therapy

Speech therapy Services to treat social, behavioral, or cognitive delays in speech or language development unless Medically Necessary.

Surrogacy

Services for anyone in connection with a surrogacy arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. Please refer to "Surrogacy arrangements" under "Reductions" in this "Exclusions, Limitations, Coordination of Benefits, and Reductions" section for information about your obligations to us in connection with a surrogacy arrangement, including your obligation to reimburse us for any Services we cover.

Travel and lodging expenses

Travel and lodging expenses, except that in some situations if the Medical Group refers you to a Non-Plan Provider as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines. 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 *Evidence of Coverage*, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor disputes. Under these extreme circumstances, if you have an Emergency Medical Condition, go to the nearest hospital as described under "Emergency Care" in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section, and we will provide coverage and reimbursement as described in that section.

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

Coordination of Benefits

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

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

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

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

Reductions

Employer responsibility

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

Government agency responsibility

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

Injuries or illnesses alleged to be caused by third parties

If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered Services, you must pay us Charges for those Services, except that the amount you must pay will not exceed the maximum amount allowed under California Civil Code Section 3040. Note: This "Injuries or illnesses alleged to be caused by third parties" section does not affect your obligation to pay Cost Sharing for these Services, but we will credit any such payments toward the amount you must pay us under this paragraph.

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

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

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

Northern California Region Members:

Northern California Third Party Liability Supervisor
Kaiser Foundation Health Plan, Inc.
Special Recovery Unit
Parsons East, Second Floor
393 E. Walnut St.
Pasadena, CA 91188

Southern California Region Members:

Southern California Third Party Liability Supervisor
Kaiser Foundation Health Plan, Inc.
Special Recovery Unit
Parsons East, Second Floor
393 E. Walnut St.
Pasadena, CA 91188

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

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

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

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

Medicare benefits

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

Surrogacy arrangements

If you enter into a surrogacy arrangement, you must pay us Charges for covered Services you receive related to conception, pregnancy, or delivery in connection with that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed 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. Note: This "Surrogacy arrangements" section does not affect your obligation to pay Cost Sharing for these Services, but we will credit

any such payments toward the amount you must pay us under this paragraph.

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:

Surrogacy Third Party Liability Supervisor
Kaiser Foundation Health Plan, Inc.
Special Recovery Unit
Parsons East, Second Floor
393 E. Walnut St.
Pasadena, CA 91188

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

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

U.S. Department of Veterans Affairs

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

Workers' compensation or employer's liability benefits

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

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

Dispute Resolution

Grievances

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

You can file a grievance for any issue. Here are some examples of reasons you might file a grievance:

- You are not satisfied with the quality of care you received
- You received a written denial of Services from the Medical Group or a "Notice of Non-Coverage" and you want us to cover the Services
- A Plan Physician has said that Services are not Medically Necessary and you want us to cover the Services
- You were told that Services are not covered and you believe that the Services should be covered
- You received care from a Non-Plan Provider that we did not authorize (other than Emergency Care, Post-Stabilization Care, or Out-of-Area Urgent Care) and you want us to pay for the care
- We did not decide fully in your favor on a claim for Services described in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section and you want to appeal our decision

- You are dissatisfied with how long it took to get Services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility

Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about Services you received. You must submit your grievance orally or in writing within 180 days of the date of the incident that caused your dissatisfaction as follows:

- If we did not decide fully in your favor on a claim for Services described in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section and you want to appeal our decision, you can submit your grievance in one of the following ways:
 - ♦ to the Claims Department at the following address:

Northern California Region Members:

Kaiser Foundation Health Plan, Inc.
Special Services Unit
P.O. Box 23280
Oakland, CA 94623

Southern California Region Members:

Kaiser Foundation Health Plan, Inc.
Special Services Unit
P.O. Box 7136
Pasadena, CA 91109

- ♦ by calling our Member Service Call Center at 1-800-464-4000 or 1-800-390-3510 (TTY users call 1-800-777-1370)
- For all other issues, you can submit your grievance in one of the following ways:
 - ♦ to the Member Services Department at a Plan Facility (please refer to *Your Guidebook* for addresses)
 - ♦ by calling our Member Service Call Center at 1-800-464-4000 (TTY users call 1-800-777-1370)
 - ♦ through our Web site at **kp.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 do not approve your request, we will tell you the reasons and about additional dispute resolution options. Note: If we resolve your issue to your satisfaction by the end of the next business day after we receive your grievance orally, by fax, or through our Web site, and a Member Services representative notifies

you orally about our decision, we will not send you a confirmation letter or a written decision unless your grievance involves a coverage dispute, a dispute about whether a Service is Medically Necessary, or an experimental or investigational treatment.

Expedited grievance

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

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

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

- Call our Expedited Review Unit toll free at 1-888-987-7247 (TTY users call 1-800-777-1370), which is available Monday through Saturday from 8:30 a.m. to 5 p.m. After hours, you may leave a message and a representative will return your call the next business day
- Send your written request to:

Northern California Region Members:

Kaiser Foundation Health Plan, Inc.
Expedited Review Unit
P.O. Box 23170
Oakland, CA 94623-0170

Southern California Region Members:

Kaiser Foundation Health Plan, Inc.
Expedited Review Unit
P.O. Box 23170
Oakland, CA 94623-0170

- Fax your written request to our Expedited Review Unit toll free at 1-888-987-2252
- Deliver your request in person to your local Member Services Department at a Plan Facility

If we do not approve your request for an expedited decision, we will notify you and we will respond to your grievance within 30 days. If we do not approve your grievance, we will send you a written decision that tells you the reasons and about additional dispute resolution options.

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

Supporting Documents

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

Who May File

The following persons may file a grievance:

- You may file for yourself
- You may appoint someone as your authorized representative by completing our authorization form. Authorization forms are available from your local Member Services Department at a Plan Facility or by calling our Member Service Call Center. Your completed authorization form must accompany the grievance
- You may file for your Dependent under age 18, except that he or she must appoint you as his or her authorized representative if he or she has the legal right to control release of information that is relevant to the grievance
- You may file for your ward if you are a court-appointed guardian, except that he or she must appoint you as his or her authorized representative if he or she has the legal right to control release of information that is relevant to the grievance
- 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 currently effective health care proxy, to the extent provided under state law

- Your physician may request an expedited grievance as described under "Expedited grievance" in this "Dispute Resolution" section

Department of Managed Health Care Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

Independent Medical Review (IMR)

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

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

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

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

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

Experimental or investigational denials

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

- Your treating physician provided us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we cover than the therapy being requested. "Life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival. "Seriously

debilitating" means diseases or conditions that cause major irreversible morbidity

- If your treating physician is a Plan Physician, he or she recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying his or her recommendation
- You (or your Non-Plan Physician who is a licensed, and either a board-certified or board-eligible, physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician's certification included a statement of the evidence relied upon by the physician in certifying his or her recommendation. We do not cover the Services of the Non-Plan Provider

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

Binding Arbitration

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

Scope of arbitration

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

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *Evidence of Coverage* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. (Health Plan), including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), 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 your 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

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

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

"Kaiser Permanente Parties" include:

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

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

Kaiser Permanente Party against whom a claim is asserted.

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

Northern California Region Members:

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

Southern California Region Members:

Kaiser Foundation Health Plan, Inc.
Legal Department
393 E. Walnut St.
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 Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee

Waiver Form sets forth the criteria for waiving fees and is available by calling our Member Service 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 arbitrators' fees and expenses

Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the *Rules 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 the Rules of Procedure developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from our Member Service 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 (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for 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 or required by law.

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration" section.

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, 2010, your last minute of coverage was at 11:59 p.m. on December 31, 2009). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *Evidence of Coverage* after your membership terminates, except as provided under "Payments after Termination" in this "Termination of Membership" section.

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, 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, 2009, your termination date is January 1, 2010, and your last minute of coverage is at 11:59 p.m. on December 31, 2009.

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 for which premiums are taken from earnings based on an eligible appointment. If you are hospitalized or undergoing treatment of a medical condition covered by this Plan, benefits will cease to be provided and you may have to pay for the cost of those benefits yourself. You may be entitled to continued benefits under terms which are specified elsewhere in this document. (If you apply for HIPAA coverage and conversion the benefits may not be the same as you had under this Plan.)

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. For information on disenrollment procedures, contact the person who handles benefits at your location (or the UC Customer Service Center if you are a Retiree).

Termination of Agreement

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. Your

Group is required to notify Subscribers in writing if its *Agreement* with us terminates.

Termination for Cause

If you 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
- You commit theft from Health Plan, from a Plan Provider, or at a Plan Facility
- You intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider. Some examples of fraud include:
 - ◆ misrepresenting eligibility information about you or a Dependent
 - ◆ presenting an invalid prescription or physician order
 - ◆ misusing a Kaiser Permanente ID card (or letting someone else use it)
 - ◆ giving us incorrect or incomplete material information
 - ◆ failing to notify us of changes in family status or Medicare coverage that may affect your eligibility or benefits

If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future. We may also report criminal fraud and other illegal acts to the authorities for prosecution. Coverage for you or your Family Members may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. Such termination shall be effective upon the later of (1) the date shown on the written notice to you; or (2) the date of the mailing of written notice to you (and to the University if notice is given by the Plan). A Family Member who commits fraud or deception or on whose behalf you commit fraud or deception will be permanently disenrolled. If you commit fraud or deception, you and any eligible Family Members will be disenrolled for 12 months.

Termination for Fraud

Coverage for you or your Family Members may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. Such termination shall be effective upon the later of:

- the date shown on the written notice to you;
- the date of the mailing of written notice to you (and to the University if notice is given by the Plan).

A Family Member who commits fraud or deception or on whose behalf you commit fraud or deception will be permanently disenrolled. If you commit fraud or deception, you and any eligible Family Members will be disenrolled for 12 months.

Termination for Nonpayment

Nonpayment of Premiums

If your Group fails to pay Premiums for your Family (or if your Family fails to pay Premiums for Cal-COBRA coverage for your Family), we may terminate the memberships of everyone in your Family. For information about termination for nonpayment of Cal-COBRA Premiums, please refer to "Termination for nonpayment of Cal-COBRA Premiums" in the "Continuation of Membership" section.

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

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

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

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

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

Termination of a Product or all Products

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

HIPAA Certificates of Creditable Coverage

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

Payments after Termination

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

- Refund any amounts we owe your Group for Premiums paid after the termination date

- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" and "Dispute Resolution" sections. We will deduct any amounts you owe Health Plan or Plan Providers from any payment we make to you

State Review of Membership Termination

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

Continuation of Membership

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

As a participant in this plan you may be entitled to continue health care coverage for yourself, spouse or family members if there is a loss of coverage under the plan as a result of a qualifying event under the terms of the federal COBRA continuation requirements under the Public Health Service Act., as amended, and, if that continued coverage ends, you may be eligible for further continuation under California law. You or your family members will have to pay for such coverage. You may direct questions about these provisions to CONEXIS, UC's COBRA administrator or visit the website http://atyourservice.ucop.edu/employees/health_welfare/cobra.html

Continuation of Group Coverage

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

Individual Plan described under "Conversion from Group Membership to an Individual Plan" in this "Continuation of Membership" section. However, the individual plan premiums and coverage will be different from the premiums and coverage under your Group plan.

COBRA

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

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

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

Cal-COBRA

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

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

- Your effective date of COBRA coverage was on or after January 1, 2003
- You have exhausted the time limit for COBRA coverage and that time limit was 18 or 29 months
- You are not entitled to Medicare

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

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

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

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

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

Changes to Cal-COBRA coverage and Premiums.

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

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

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

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

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

- The date and time when the memberships of everyone in your Family will end if we do not receive the Premiums
- We will terminate your Family's memberships if we do not receive payment within 15 days of the date we mailed the Notice of Termination (notice of nonreceipt of payment). We will mail a notice confirming termination of membership, which will inform you of the following:
 - That we have terminated the memberships of everyone in your Family for nonpayment of Premiums
 - The date and time when the memberships of everyone in your Family ended
 - Information explaining whether or not you can reinstate your memberships

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

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

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

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Coverage for a disabling condition

If you became totally disabled 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 occurs:

- 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 *Evidence of Coverage*, including Cost Sharing.

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.

Conversion from Group Membership to an Individual Plan

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

Kaiser Permanente Conversion Plan

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

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

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

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

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

HIPAA and other individual plans

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

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

eligible person under HIPAA, you must meet the following requirements:

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

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

Leave of Absence, Layoff or Retirement

Contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff or retirement.

Miscellaneous Provisions

Administration of Agreement

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

Advance directives

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

- A Power of Attorney for Health Care lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write

down your own views on life support and other treatments

- Individual health care instructions let you express your wishes about receiving life support and other treatment. You can express these wishes to your doctor and have them documented in your medical chart, or you can put them in writing and have that included in your medical chart

To learn more about advance directives, including how to obtain forms and instructions, contact 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 *Evidence of Coverage*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *Evidence of Coverage*.

Amendment of Agreement

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

Applications and statements

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

Assignment

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

Attorney and advocate fees and expenses

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

Claims review authority

We are responsible for determining whether you are entitled to benefits under this *Evidence of Coverage* and we have the discretionary authority to review and evaluate claims that arise under this *Evidence of Coverage*. We conduct this evaluation independently by interpreting the provisions of this *Evidence of Coverage*. If this *Evidence of Coverage* is part of a health benefit plan that is subject to the Employee Retirement Income

Security Act (ERISA), then we are a "named fiduciary" to review claims under this *Evidence of Coverage*.

ERISA notices

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

Newborns' and Mother's Health Protection Act.

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

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

Governing law

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

Group and Members not our agents

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

Health Insurance Counseling and Advocacy Program (HICAP)

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

No waiver

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

Nondiscrimination

We do not discriminate 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, physical or mental disability, or genetic information.

Notices

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

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

Other formats for Members with disabilities

You can request a copy of this *Evidence of Coverage* in an alternate format (Braille, audio, electronic text file, or large print) by calling our Member Service 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. We also require contracting providers to protect your protected health information.

Protected health information 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 protected health information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your protected health information.

We may use or disclose your protected health information for treatment, 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 protected health information to government agencies or in judicial actions. In addition, Member-identifiable medical information is shared with your Group only with your authorization or as otherwise permitted by law. We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* describing our policies and procedures for preserving the confidentiality of medical records and other protected health information 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 kp.org.

Public policy participation

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

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

Telephone access (TTY)

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

Plan Administration

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

By authority of the Regents, University of California Human Resources, 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 insurance contracts. 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
300 Lakeside Drive
Oakland, CA 94612
(800) 888-8267

Retirees and Survivors may also direct questions to the UC Customer Service Center at the above phone number.

Claims under the Plan are processed by Kaiser Foundation Health Plan, Inc., at the following addresses and phone numbers:

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

Group Contract Numbers

Northern California Region

The Group contract numbers for the University of California, Northern California Region, are 603601, 603602, 603603, 603604, 603605, 603607, 603608, 603609, 603610, 603611, 603612, 603613, 603614, 603616, and 603624.

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, 230154 and 230156.

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 portion of the premiums that 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 plan costs are 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 *Evidence of Coverage*. To file a claim or to file an appeal regarding denied claims of benefits or services, refer to the appeal section found in this document. Any appeals regarding coverage denials that relate to eligibility requirements are subject to the UC Group Insurance Regulations. To obtain a copy of the Eligibility Claims Appeal Process, please contact the person who handles benefits at your

location (or the UC Customer Service Center if you are a retiree).

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

1-800-464-4000 (English)

1-800-788-0616 (Spanish)

1-800-757-7585 (Chinese dialects)

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

7 a.m. to 7 p.m., Monday through Friday

7 a.m. to 3 p.m., weekends

kp.org



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