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

Kaiser Foundation Health Plan, Inc.
Northern California and Southern California Regions
Effective January 1, 2007

KAISER PERMANENTE

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2007 Summary of Changes and Clarifications

The following is a summary of the most important changes and clarifications that we have made to this 2006 *Disclosure Form and Evidence of Coverage (DF/EOC).*

Please refer to the "Benefits and Cost Sharing" section in this *DF/EOC* for benefit descriptions and the amount Members must pay for covered benefits. Benefits are also subject to the "Emergency, Post-stabilization, and Out-of-Area Urgent Care from Non–Plan Providers" and the "Exclusions, Limitations, Coordination of Benefits, and Reductions" sections.

Changes

Grievance timeframe

We have established a time limit for non-Medicare Members to file grievances. Members who want to make a request for Services or file a grievance must do so *within 180 days of the denial date or the date of the incident that caused his or her dissatisfaction*.

Hospice care

For non-Medicare Members, we now cover hospice care inside our Service Area a*nd inside California but within 15 miles or 30 minutes from our Service Area*. Previously, we covered hospice care only within our Service Area. We made this change to comply with a recent benefit ruling by the Department of Managed Health Care.

Also, care in the home when the home is not a safe and effective treatment setting is not listed as an exclusion under "Hospice Care" in the "Benefits and Cost Sharing" section of this *DF/EOC*. However, if a Plan Physician determines that a Member's home is not a safe and effective treatment setting for hospice care, we may offer to provide or arrange hospice care in another setting.

Medicare Part D creditable coverage notice

We will state in all non-Medicare *EOCs* with supplemental outpatient prescription drug coverage that *your Group must notify all its employees who are eligible for Medicare whether drug coverage through your Group is creditable Medicare Part D coverage*. A Medicare beneficiary who does not enroll in Medicare Part D during his or her initial Medicare eligibility period may be subject to the Medicare Part D late enrollment penalty if he or she does not have creditable Medicare Part D coverage.

Network change

Members in western Ventura County and Coachella Valley (except in the Joshua Tree and Yucca Valley areas) must receive primary care from Medical Group physicians. Previously, primary care in these areas was provided by non-Medical Group physicians with whom the Medical Group contracted (called Affiliated Plan Physicians). Therefore, we are removing all references to Affiliated Plan Providers and special rules relating to obtaining care in those areas. This change applies to all Members except that our Senior Advantage Service Area currently does not include western Ventura County.

The Service Area of our Southern California Region now includes additional parts of Riverside County in the following Zip codes 92589-93 (the Temecula area). Members may obtain care from Plan Providers in this area, including Inland Valley Medical Center in Wildomar, California and Rancho Springs Medical Center in Murrieta, California.

Osseointegrated external hearing devices

We now cover osseointegrated external hearing devices for non-Medicare Members at no charge (subject to any Deductible). These implanted devices were previously covered only for Medicare Members. We made this change because the Medical Group recommended that we cover these devices for all Members.

Termination for nonpayment of charges (other than Premiums)

We have deleted the "Termination for nonpayment of any other charges" provision from all *EOC*s because our practice is to refer any bad debt to collection agencies.

Clarifications

Benefit refresh

The maximum number of Medically Necessary contact lenses we cover to treat aniridia (missing iris) includes lenses we covered under another *EOC* offered by your Group. Also, we have clarified that the benefit limit for contact lenses to treat aphakia (absence of the crystalline lens of the eye) and care in a Skilled Nursing Facility for non-Medicare Members includes Services we covered under another *EOC* offered by your Group.

Binding Arbitration

We have added KP Cal, LLC, a subsidiary to Kaiser Foundation Health Plan, Inc., to the list of Kaiser Permanente Parties in the "Binding Arbitration" provision in this *DF/EOC*.

We have added the definition of "malpractice" from Section 1295 of the California Code of Civil Procedure under "Binding Arbitration" in the "Dispute Resolution" section of this *DF/EOC*. Section 1295 defines Medical or hospital malpractice as "a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered."

Cosmetic Services exclusion

Cosmetic Services are Services that are intended primarily to change or maintain appearance. Previously, the exclusion stated that cosmetic Services are primarily intended to improve appearance.

Definitions

The definition of "Allowance" has been revised to clarify that any amount a Member pays in excess of the Allowance does not apply to any Deductible or out-of-pocket maximum because the excess amount is not covered.

We now use the term "Cost Sharing" to describe the amount a Member is required to pay for a covered Service (for example, Deductibles, Copayments, or Coinsurance).

We use the term "Premiums" rather than "Dues" to describe periodic membership charges paid by or on behalf of a Member.

Disposable supplies for home use exclusion

We have clarified that the exclusion for disposable supplies for home use includes diapers, underpads, and other incontinence supplies, and we have also noted that the disposable supplies exclusion does not apply to supplies provided in relation to covered durable medical equipment, home health care, hospice care, ostomy and urological supplies, and outpatient prescription drugs as described in the "Benefits and Cost Sharing" section.

Dispute resolution

We have noted that if we resolve a Member's complaint to his or her satisfaction by the end of the next business day after we receive it, and a Member Services representative notifies the Member orally about our decision, we will not send a confirmation letter or a written decision unless the grievance involves a coverage dispute, a dispute about whether a Service is Medically Necessary, or an experimental or investigational treatment.

Limitations

In the "Limitations" section of this *DF/EOC*, we have noted that limitations that apply to a particular benefit are described under the applicable heading in the "Benefits and Cost Sharing" section.

Outpatient imaging, laboratory, and special procedures

In the "Outpatient Imaging, Laboratory, and Special Procedures" section of this *DF/EOC*, we have clarified that special procedures are diagnostic procedures other than diagnostic imaging and laboratory Services, such as electrocardiograms and electroencephalograms, provided by Plan Providers who are not Plan Physicians.

Outpatient procedures and outpatient surgery

We have deleted the reference to "anesthesia" in the description of "outpatient surgery" and "other outpatient procedures" throughout the "Benefits and Cost Sharing" section of this *DF/EOC* because Plan Physicians may prescribe sedation instead of anesthesia.

Prenatal care

In the "Outpatient Care" section of this *DF/EOC*, we have deleted the reference to the Obstetrical Department in the description of coverage for prenatal care visits because the care is also provided in other departments. Also, we have clarified that the Cost Sharing for prenatal care visits applies only to the normal series of regularly scheduled prenatal visits; other visits are covered at the Cost Sharing that would otherwise apply.

Prescription drug coverage

We are clarifying that we may reduce the day supply of prescription drugs we provide at the Cost Sharing indicated to a 30 day supply in any 30 day period if a drug is in limited supply in the market.

We have clarified that Members may be required to pay for and file a claim for reimbursement for prescription drugs written by Non–Plan physicians in conjunction with covered Emergency Care and Out-of-Area Urgent Care that are filled at our Pharmacies.

We have clarified that items prescribed by Non–Plan Physicians are covered in the following circumstances unless a Plan Physician determines that the drug, supply, or supplement is not Medically Necessary or the drug is for a sexual dysfunction disorder:

- If the Medical Group authorizes a referral to the Non–Plan Physician and the item is covered as part of that referral
- If the prescription is received in conjunction with covered Emergency Care, Post-stabilization Care, Post-stabilization Care, or Out-of-Area Urgent Care

If applicable, the disclosure of dose limits for drugs prescribed to treat sexual dysfunction disorders now appears under the "Day supply limit" heading in this *DF*/*EOC*. This information was previously listed with the Cost Sharing for these drugs.

Repair and replacement

We have clarified that the Cost Sharing specified for durable medical equipment (DME) and prosthetic and orthotic devices applies to repair and replacement of covered items. Also, the Cost Sharing for repair and replacement of covered DME applies toward any benefit limit for DME.

Third party liability and surrogacy reductions

We have revised the "Injuries or illness alleged to be caused by their parties" reduction to clarify the maximum amount we may recover and a Member's liability for Cost Sharing:

> 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 "injury 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.

Corresponding changes have been made to the "Surrogacy Services" reduction*:*

> 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.

Benefit Highlights

Annual Out-of-Pocket Maximum	
For any one Member	$1,500 per calendar year
For an entire Family Unit of two or more Members	$3,000 per calendar year
Deductible	None
Lifetime Maximum	
Services covered under "Transgender Services" in the "Benefits and Cost Sharing" section	$75,000
All other Services	None
Coordination of Benefits	Included
Professional Services (Plan Provider office visits)	**You Pay**
Primary and specialty care visits (includes routine and Urgent Care appointments)	$15 per visit
Routine preventive physical exams	$15 per visit
Well-child preventive care visits (0-23 months)	No charge
Family planning visits	$15 per visit
Scheduled prenatal care and first postpartum visit	No charge
Eye exams	$15 per visit
Hearing tests	$15 per visit
Physical, occupational, and speech therapy visits	$15 per visit
Outpatient Services	**You Pay**
Outpatient surgery	$15 per procedure
Allergy injection visits	$5 per visit
Allergy testing visits	$15 per visit
Vaccines (immunizations)	No charge
X-rays and lab tests	No charge
Health education	$15 per individual visit No charge for group visits
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	$250 per admission
Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit (does not apply if admitted directly to the hospital as an inpatient)
Ambulance Services	**You Pay**
Ambulance Services	No charge
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary from Plan Pharmacies or from our mail order program:	
Generic items	$10 for up to a 100 day supply
Brand name items	$20 for up to a 100 day supply
Durable Medical Equipment	**You Pay**
Covered durable medical equipment for home use in accord with our DME formulary	No charge

Mental Health Services	You Pay
Inpatient psychiatric care	$250 per admission
Outpatient individual and group therapy visits	$15 per individual therapy visit $7 per group therapy visit
Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the "Benefits and Cost Sharing" section.	

Chemical Dependency Services	You Pay
Inpatient detoxification	$250 per admission
Outpatient individual therapy visits	$15 per visit
Outpatient group therapy visits	$5 per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission

Home Health Services	You Pay
Home health care (up to 100 two-hour visits per calendar year)	No charge

Other	You Pay
Hearing aid(s) every 36 months	$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, exclusions, or limitations, and it does not list all benefits, Copayments, and Coinsurance. For a complete explanation, please refer to the "Benefits and Cost Sharing" and "Exclusions, Limitations, Coordination of Benefits, and Reductions" sections.

Introduction

This *Disclosure Form and Evidence of Coverage (DF/EOC)* describes the health care coverage of "Kaiser Permanente Traditional Plan" (which is not a federally qualified health benefit plan) provided under the *Group Agreement (Agreement)* between Kaiser Foundation Health Plan, Inc. (Health Plan), Northern California Region and Southern California Region, and the University of California (Group). For benefits provided under any other Health Plan program, refer to that plan's evidence of coverage.

In this *DF/EOC*, Kaiser Foundation Health Plan, Inc., is sometimes referred to as "Health Plan," "we," or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *DF/EOC*; please see the "Definitions" section for terms you should know.

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

Term of this *DF/EOC*

This *DF/EOC* is for the period January 1, 2007, through December 31, 2007, unless amended. Your Group's benefits administrator can tell you whether this *DF/EOC* is still in effect and give you a current one if this *DF/EOC* has expired or been amended.

About Kaiser Permanente

Kaiser Permanente provides Services directly to our Members through an integrated medical care program. 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 preventive care programs and healthy living (health education) classes 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 following sections about:

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

Definitions

When capitalized and used in any part of this *DF/EOC*, 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: Emergency Care is:

- 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: 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.

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

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. This *DF/EOC* sometimes refers to Health Plan as "we" or "us."

Kaiser Permanente: Kaiser Foundation Hospitals (a California nonprofit corporation), Health Plan, and 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: A federal health insurance program for people age 65 and older, certain disabled people, and those with end-stage renal disease (ESRD). In this *DF/EOC*, 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 *DF/EOC*, and for whom we have received applicable Premiums. This *DF/EOC* sometimes refers to a Member as "you."

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

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

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

Out-of-Area Urgent Care: An Urgent Care need requires prompt medical attention, but is not an Emergency Medical Condition. Out-of-Area Urgent Care is Medically Necessary Services 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: Post-stabilization Care is Medically Necessary Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable.

Premiums: Periodic membership charges paid by your Group.

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

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

Service Area:

Northern California Region Service Area

The following counties are entirely inside our Service Area: Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, San Mateo, Solano, and Stanislaus. Portions of the following counties 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, 93740-41, 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, 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, 95101-03, 95106, 95108-42, 95148, 95150-61, 95164, 95170-73, 95190-94, 95196
- Sonoma: 94515, 94922-23, 94926-28, 94931, 94951-55, 94972, 94975, 94999, 95401-09, 95416, 95419, 95421, 95425, 95430-31, 95433, 95436, 95439, 95441-42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471-73, 95476, 95486-87, 95492
- Sutter: 95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 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, 93250-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-14, 93380-90, 93501-02, 93504-05, 93518-19, 93531, 93536, 93560-61, 93581
- Los Angeles: 90001-84, 90086-89, 90091, 90093-96, 90099, 90101-03, 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, 90301-13, 90397-98, 90401-11, 90501-10, 90601-10, 90612, 90623, 90630-31, 90637-40, 90650-52, 90659-62, 90665, 90670-71, 90701-03, 90706-07, 90710-17, 90723, 90731-34, 90744-49, 90755, 90801-10, 90813-15, 90822, 90831-35, 90840, 90842, 90844-48, 90853, 90888, 90899, 91001, 91003, 91006-07, 91009-12, 91016-17, 91020-21, 91023-25, 91030-31, 91040-43, 91046, 91066, 91077, 91101-10, 91114-18, 91121, 91123-26, 91129, 91131, 91182, 91184-85, 91187-89, 91191, 91199, 91201-10, 91214, 91221-22, 91224-26, 91301-13, 91316, 91321-22, 91324-31, 91333-35, 91337, 91340-46, 91350-57, 91361-65, 91367, 91371-72, 91376, 91380-388, 91390, 91392-96, 91399, 91401-13, 91416, 91423, 91426, 91436, 91470, 91482, 91495-97, 91499, 91501-08, 91510, 91521-23, 91526, 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, 91797, 91799, 91801-04, 91841, 91896, 91899, 93243, 93510, 93532, 93534-36, 93539, 93543-44, 93550-53, 93560, 93563, 93584, 93586, 93590-91, 93599
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- Ventura: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93001-07, 93009, 93010-12, 93015-16, 93020-21, 93022, 93030-36, 93040, 93041-44, 93060-61, 93062-66, 93093-94, 93099, 93252

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.

Single-source Generic Drugs: Generic drugs that are available in the United States only from a single manufacturer and that are not listed as generic in the then-current commercially available drug database(s) to which Health Plan subscribes.

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 *DF/EOC*, 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, that we approve.

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. If you are responsible for any contribution to the Premiums, 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 deenrolled 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 Subscriber must live or work in our Service Area at the time he or she enrolls. The "Definitions" section describes our Service Area and how it may change. You cannot enroll or continue enrollment as a Subscriber or Dependent if you live in or move to a Region outside California except as described below. If you move anywhere else outside our Service Area after enrollment, you can continue your membership as long as you meet all other eligibility requirements. However, you must receive covered Services from Plan Providers inside our Service Area, except as described in the following sections about:

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

Regions outside California. If you live in or move to the service area of a Region outside California, you are not eligible for membership under this *DF/EOC* (unless you are a Subscriber who works inside our Service Area or you are a Dependent child of the Subscriber or the Subscriber's Spouse). Please contact your Group's benefits administrator to learn about your Group health care options. You may be able to enroll in the new service area if there is an agreement between your Group and that Region, but the coverage, premiums, and eligibility requirements will not be the same.

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 a service area in another Region. See "Visiting other Regions" in the "How to Obtain Services" section for information.

Our Northern California Region and Southern California Region 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 *DF/EOC* applies when you obtain care in your Home Region. When you visit the other California Region, you may receive care as described in "Visiting other Regions" in the "How to Obtain Services" section.

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:

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

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 Factsheet for Retirees and Eligible Family Members*.

If you are eligible for Medicare, you must follow UC's Medicare Rules. See "Effect of Medicare on Retiree enrollment" in this "Who Is Eligible" section.

Eligible Dependents (Family Members)

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

Spouse. Your legal Spouse.

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

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

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

- the incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous;
- the child is claimed as your dependent for income tax purposes or is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment that may offset the Social Security or Supplemental Security Income; and
- the child lives with you if he or she is not your or your Spouse's natural or adopted child.

We must receive your application at least 31 days before the child's 23rd birthday and we must approve the application. We may periodically request proof of continued disability. Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired Employee with an incapacitated child, you may also apply for coverage for that child. The child must have had continuous group medical coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility (PIE).

Other eligible Dependents (Family Members)

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

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

An adult dependent relative is no longer eligible for coverage. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003, 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 Customer Service Center. You may also access eligibility factsheets on the 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 has been terminated for cause due to fraud under this *DF/EOC* will be permanently deenrolled while any other Family Member and the Subscriber will be deenrolled for 12 months. If a Subscriber commits fraud or deception, the Subscriber and any Family Members will be deenrolled for 12 months

Effect of Medicare on Retiree enrollment

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

a) Individuals who were eligible for premium-free Part A, but not enrolled in Medicare Part B prior to July 1, 1991.
b) 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 the Hospital (Part A) and Medical (Part B) portions of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

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

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care Contract must assign his/her Medicare benefit to that plan or lose UC-sponsored medical coverage. 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 deenrolled from this health plan.

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. 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 Employees or their Spouses who are age 65 or older and 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 should carefully consider the impact on your health benefits and premiums should you decide to return to work after you retire.

Medicare late enrollment penalty. If you become eligible for Medicare Part B or D and do not enroll during the initial Medicare enrollment period, Medicare may require you to pay a late enrollment penalty to Medicare or to us. In the case of Medicare Part D, the late enrollment penalty applies if you go 63 days or longer without Medicare Part D creditable prescription drug coverage, which means prescription drug coverage that is at least as good as the standard Medicare Part D prescription drug coverage. If you are or become eligible for Medicare Part D, your group is responsible for informing you about whether your drug coverage under this plan is Medicare Part D creditable prescription drug coverage.

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

Medicare private contracting provision and Providers Who do Not Accept Medicare

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

Some physicians or practitioners have **never** participated in Medicare. Their services (that would be covered by Medicare if they participated) will not be covered by Medicare or this Plan, and the Medicare limiting charge will not apply.

If you are classified as a Retiree by the University (or otherwise have Medicare as a primary coverage), are enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement as described above with one or more physicians or practitioners, or if you choose to obtain services from a provider who does not participate in Medicare, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. In either case, no benefits will be paid by this Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered. Therefore, it is important that you confirm that your provider takes Medicare prior to obtaining services for which you wish the Plan to pay.

However, even if you do sign a private contract or obtain services from a provider who does not participate in Medicare, you may still see **other** providers who have not opted out of Medicare and receive the benefits of this Plan for those services.

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 University's Customer Service Center. Enrollment transactions may be completed by paper form or electronically, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits Office or by the University's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

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

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

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

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

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

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

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

If you are in an HMO plan and you move or are transferred out of that plan's service area, or will be away from the plan's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan. Your PIE starts with the effective date of the move or the date you leave the plan's service area.

At other times for Employees and Retirees

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

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

If you are an Employee or Retiree and fail to enroll your eligible Family Members during a PIE or open enrollment period, you may enroll your eligible Family Members at any other time upon completion of a 90 consecutive calendar-day waiting period.

The 90-day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits Office and ends 90 consecutive calendar days later.

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

If you are 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 University's 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. You must elect to continue enrollment for yourself and enrolled Family Members before the effective date of retirement (or the date disability or survivor benefits begin).

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

Effective date

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

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

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

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

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

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

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

Change in coverage

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

How to Obtain Services

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

- Emergency ambulance Services, described under "Ambulance Services" in the "Benefits and Cost Sharing" section
- Emergency Care, Post-stabilization Care, and Out-of-Area Urgent Care, in the "Emergency, Post-stabilization, and Out-of-Area Urgent Care from Non–Plan Providers" section
- Getting a referral, in this "How to Obtain Services" section
- Hospice care 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.

Your Primary Care Plan Physician

Your primary care Plan Physician plays an important role in coordinating your medical care needs, including hospital stays and referrals to specialists. We encourage you to choose a primary care Plan Physician. You may select a primary care Plan Physician from any of our available Plan Physicians who practice in these specialties: internal medicine, family medicine, and pediatrics. Also, women can select any available primary care Plan Physician from obstetrics/gynecology. You can change your primary care Plan Physician for any reason. To learn how to select a primary care Plan Physician, please call our Member Service Call Center. You can find a directory of our Plan Physicians on our Web site at **kp.org**.

Routine Care

If you need to make a routine care appointment, please refer to *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 checkups 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 (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. Whether you are calling for advice or to make an appointment, you can speak to an advice nurse. They can often answer questions about a minor concern, 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.

Getting a Referral

Referrals to Plan Providers

Primary care. Primary care Plan Physicians provide primary medical care, including pediatric care and obstetrics/gynecology care. You don't need a referral to receive primary care from Plan Physicians in the following areas: internal medicine, family medicine, obstetrics/gynecology, family planning, and pediatrics.

Specialty care. Plan Physicians who are specialists provide specialty care in areas such as surgery, orthopedics, cardiology, oncology, urology, and dermatology. A Plan Physician must refer you before you can be seen by one of our specialists except that you do not need a referral to receive care in the following areas: optometry, psychiatry, and chemical dependency. Please check *Your Guidebook* to see if your facility has other departments that don't require a referral.

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):

- **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
- **Bariatric surgery.** If your Plan Physician makes a written referral for bariatric surgery, the Medical Group's regional bariatric medical director or his or her designee will authorize the Service if he or she determines that it is Medically Necessary. The Medical Group's criteria for determining whether bariatric surgery is Medically Necessary are described in the Medical Group's bariatric surgery referral criteria, which are available upon request
- **Durable medical equipment (DME).** If your Plan Physician prescribes a DME item, he or she will submit a written referral to the Plan Hospital's DME coordinator, who will authorize the DME item if he or she determines that your DME coverage includes the item and that the item is listed on our formulary for your condition. If the item doesn't appear to meet our DME formulary guidelines, then the DME coordinator will contact the Plan Physician for additional information. If the DME request still doesn't appear to meet our DME formulary guidelines, it will be submitted to 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 DME 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

- **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
- **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

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, tests, 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 same as that 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.

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 enrollment with us will end your prior plan's coverage of the provider's Services, 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 (i) 12 months from your effective date of coverage if you are a new Member, (ii) 12 months from the termination date of the terminated

provider, or (iii) 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 (i) 12 months from the child's effective date of coverage if the child is a new Member, (ii) 12 months from the termination date of the terminated provider, or (iii) 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
- 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 *DF/EOC* 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 same as that 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 and 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 by an appropriately qualified medical professional. This is a physician who is acting within his or her scope of practice and who possesses a clinical background related to the illness or condition associated with the request for a second medical opinion. You can either ask your Plan Physician to help you arrange for a second medical opinion, or you can make an appointment with another Plan 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.

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

Cost Sharing. The Cost Sharing for these referral Services is the same as that 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 cost 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 *DF/EOC*.

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 Identification Card

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

Your ID card is for identification only. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-Member for any Services he or she receives. If you let someone else use your ID card, we may keep your ID card and terminate your membership 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 primary care Plan Physician or with other Plan Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Most Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Call Center representatives are available to assist you weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m. (except holidays) at 1-800-464-4000 or 1-800-777-1370 (TTY for the hearing/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 "Requests for Payment or Services" section or with any issues as described in the "Dispute Resolution" section.

Plan Facilities

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

- 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

- Medical Offices: 3400 Delta Fair Blvd. and 5601 Deer Valley Rd.

Campbell

- Medical Offices: 220 E. Hacienda Ave.

Clovis

- Medical Offices: 2071 Herndon Ave.

Concord

- Hospital: 2540 East St. (Mount Diablo Medical Center)

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

- Medical Offices: 3800 Dale Rd. and 4125 Bangs Ave.
- 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.

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: 900 Kiely Blvd.
- Medical Offices: 710 Lawrence Expressway

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

- Medical Offices: 3700 Vaca Valley Pkwy.

Vallejo

- Hospital and Medical Offices: 975 Sereno Dr.

Walnut Creek

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

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.
- Hospital: 1111 W. La Palma Ave. (Anaheim Memorial Medical Center)
- Medical Offices: 411 N. Lakeview Ave. and 1188 N. Euclid St.

Bakersfield

- Hospitals: 420 34th St. (Memorial Hospital), 2215 Truxtun Ave. (Mercy Hospital), and 300 Old River Rd. (Mercy Southwest Hospital)
- Medical Offices: 1200 Discovery Dr., 3501 Stockdale Hwy., 3700 Mall View Rd., and 8800 Ming Ave.

Baldwin Park

- Hospital and Medical Offices: 1011 Baldwin Park Blvd.

Bellflower

- Hospital and Medical Offices: 9400 E. Rosecrans Ave.

Bonita

- Medical Offices: 3955 Bonita Rd.

Brea

- Medical Offices: 1900 E. Lambert 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.

Downey

- Medical Offices: 9449 E. Imperial Hwy.

El Cajon

- Medical Offices: 250 Travelodge Dr. and 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.

Fountain Valley

- Hospital: 9920 Talbert Ave. (Orange Coast Memorial Medical Center)

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: 16200 Sand Canyon Ave. (Irvine Regional Hospital)
- 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 Joshua Tree and Yucca Valley 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 North 10th St. West (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. (Culver Marina Medical Offices)

Mission Viejo

- Medical Offices: 23781 Maquina Ave.

Montebello

- Medical Offices: 1550 Town Center Dr.

Moreno Valley

- Medical Offices: 12815 Heacock St.

Murrieta

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

Ontario

- Medical Offices: 1025 W. "I" St. and 2295 S. Vineyard Ave.

Oxnard

- Hospital: 1600 N. Rose Ave. (St. John's Regional Medical Center)
- Medical Offices: 2103 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: 450 N. Lake Ave.

Rancho Cucamonga

- Medical Offices: 10850 Arrow Rte.

Rancho Mirage

- Hospital: 39000 Bob Hope Dr. (Eisenhower Medical Center)

Redlands

- Medical Offices: 25828 Redlands Blvd.

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 Fordham 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

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.

Thousand Oaks

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

Torrance

- Medical Offices: 20790 Madrona Ave.

Ventura

- Hospital: 147 N. Brent St. (Community Memorial Hospital of San Buenaventura)
- Medical Offices: 1000 S. Hill Rd.

Victorville

- Medical Offices: 14011 Park Ave.

Vista

- Medical Offices: 780 Shadowridge Dr.

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.

Yorba Linda

- Medical Offices: 22550 E. Savi Ranch Pkwy.

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 calling our Member Service Call Center or by visiting our Web site at **kp.org**.

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

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

Emergency, 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

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 the Services you receive after your treating physician determines that your Emergency Medical 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 for Post-stabilization Care from a Non–Plan Provider, you must call us at **1-800-225-8883** (TTY 711) or the notification telephone number on your 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 your Post-stabilization Care would be covered if you received it from a Plan Provider, we will authorize your care from the Non–Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. If we decide to have a Plan 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

Follow-up Care

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

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 in conjunction with 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. To request payment or reimbursement, you must file a claim as described under "Requests for Payment" in the "Requests for Payment or Services" section.

Cost Sharing

The Cost Sharing for Emergency Care, Post-stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider is the same as that 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

The Services described in this "Benefits and Cost Sharing" section are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except where specifically noted to the contrary in the following sections about:
  - ♦ emergency ambulance Services, described under "Ambulance Services" in this "Benefits and Cost Sharing" section
  - ♦ Emergency Care, Post-stabilization Care, and Out-of-Area Urgent Care, 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 following sections about:
  - ♦ emergency ambulance Services, described under "Ambulance Services" in this "Benefits and Cost Sharing" section
  - ♦ Emergency Care, Post-stabilization Care, and Out-of-Area Urgent Care, in the "Emergency, Post-stabilization, and Out-of-Area Urgent Care from Non–Plan Providers" section
  - ♦ getting a referral, in the "How to Obtain Services" section
  - ♦ hospice care, described under "Hospice Care" in this "Benefits and Cost Sharing" section

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

- The "Emergency, 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 (Copayments and Coinsurance)

When you receive covered Services, you must pay your Cost Sharing amount as described in this "Benefits and Cost Sharing" section at the time you receive the Services.

In some cases, we may agree to bill you for your Cost Sharing amount, and if we do we will add a $13.50 billing fee and send you a bill for the entire amount. This $13.50 billing fee will not count toward the annual out-of-pocket maximum.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service is described in this "Benefits and Cost Sharing" section. Copayments or Coinsurance are due when you receive the Service. However, before you can schedule an elective infertility procedure, you must pay the Copayment or Coinsurance for the procedure along with any past-due, infertility-related Copayments and Coinsurance. For items ordered in advance, you pay the Copayment or Coinsurance in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Copayment or Coinsurance before the item is ordered.

Annual out-of-pocket maximum

There is a limit to the total amount of Cost Sharing you must pay under this *DF/EOC* 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 Services" in this "Benefits and Cost Sharing" section, do not apply to the annual out-of-pocket maximum. The limit is **$1,500** for any one Member or **$3,000** for an entire Family Unit of two or more Members.

Payments that count toward the maximum**.** The Copayments and Coinsurance you pay for the following Services apply toward the annual out-of-pocket maximum, unless the Services are covered under "Transgender Services" in this "Benefits and Cost Sharing" section:

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

Keeping track of the maximum**.** When you pay a Copayment or Coinsurance for these Services, ask for and keep the receipt. When the receipts add up to the annual out-of-pocket maximum, please call our Member Service Call Center to find out where to turn in your receipts. When you turn them in, we will give you a document stating that you don't have to pay any more Cost Sharing for these Services through the end of the calendar year.

Outpatient Care

We cover the following outpatient care for preventive medicine, diagnosis, and treatment subject to the Copayment or Coinsurance indicated:

- Primary and specialty care visits: **a $15 Copayment per visit**, except for the following:
  - well-child preventive care visits (0–23 months): **no charge**
  - after confirmation of pregnancy, the normal series of regularly scheduled prenatal visits and the first postpartum visit: **no charge**
  - allergy injection visits: **a $5 Copayment per visit**
- Routine preventive physical exams, including well-woman visits: **a $15 Copayment per visit**
- Hearing tests to determine the need for hearing correction: **a $15 Copayment per visit**
- Refraction exams to determine the need for vision correction and to provide a prescription for eyeglass lenses: **a $15 Copayment per visit**
- Up to two Medically Necessary contact lenses, fitting, and dispensing per eye every 12 months (including lenses we covered under another 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 another evidence of coverage offered by your Group) to treat aphakia (absence of the crystalline lens of the eye) for children from birth through age 9: **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**
- 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**
- Emergency Department visits: **a $50 Copayment per visit**. This Copayment does not apply if you are admitted directly to the hospital as an inpatient (it does apply if you are admitted as anything other than an inpatient; for example, it does apply if you are admitted for observation)
- House calls inside our Service Area when care can best be provided in your home as determined by a Plan Physician: **no charge**
- Blood, blood products, and their administration: **no charge**
- Administered drugs (drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials) if administration or observation by medical personnel is required: **no charge** if they are administered to you in a Plan Medical Office or during home visits
- Vaccines (immunizations) approved for use by the federal Food and Drug Administration (FDA) and administered to you in a Plan Medical Office: **no charge**
- Some types of outpatient visits may be available as group appointments, which are covered at **a $7 Copayment per visit**

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 Services
- 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 (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
- Physical, occupational, and speech therapy (including treatment in our organized, multidisciplinary rehabilitation program)
- Respiratory therapy
- Medical social services and discharge planning

The following types of inpatient Services are covered only as described under the following headings in this "Benefits 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 Services
- 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

We cover the following Services for treatment of chemical dependency at **a $15 Copayment per visit** for individual therapy visits and **a $5 Copayment per visit** for group therapy visits:

- Day treatment programs
- Intensive outpatient programs
- Counseling (both individual and group visits) for chemical dependency
- Medical treatment for withdrawal symptoms
- Methadone maintenance treatment for pregnant Members during pregnancy and for two months after delivery at a licensed treatment center approved by the Medical Group. We do not cover methadone maintenance treatment in any other circumstances

Transitional residential recovery Services

We cover up to 60 days per calendar year of chemical dependency treatment in a nonmedical transitional residential recovery setting approved in writing by the Medical Group. We cover these Services at **a $100 Copayment per admission**. We do not cover more than 120 days of covered care in any five consecutive calendar year period. These settings provide counseling and support services in a structured environment.

Note: The following Services are not covered under this "Chemical Dependency Services" section:

- Outpatient laboratory Services (instead, refer to "Outpatient Imaging, Laboratory, and Special Procedures" in this "Benefits and Cost Sharing" section)
- Outpatient self-administered drugs (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section)

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.

Note: Outpatient prescription drugs are not covered under this "Dental Services for Radiation Treatment and

Dental Anesthesia" section (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section).

Dialysis Care

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

- The Services are provided inside our Service Area
- You satisfy all medical criteria developed by 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**

Note: The following Services are not covered under this "Dialysis Care" section:

- Laboratory Services (instead, refer to "Outpatient Imaging, Laboratory, and Special Procedures" in this "Benefits and Cost Sharing" section)
- Outpatient prescription drugs (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section)
- Outpatient administered drugs (instead, refer to "Outpatient Care" in this "Benefits and Cost Sharing" section)

Durable Medical Equipment for Home Use

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

Inside our Service Area, we cover DME items in accord with our DME formulary guidelines for use in your home (or another location used as your home inside our Service Area). Coverage is limited to the standard item of equipment that adequately meets your medical needs. Covered DME, including repair and replacement of covered DME, is covered at **no charge**.

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

Outside the Service Area

We do not cover most DME for home use outside our Service Area. However, our DME formulary guidelines allow certain DME items (such as crutches and canes) for use in your home (or another location used as your home) to be picked up from Plan Facilities even if you live outside our Service Area. To find out whether we will cover a particular DME item if you live outside our Service Area, please call our Member Service Call Center.

About our DME formulary

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

Our formulary guidelines allow you to obtain nonformulary DME items (those not listed on our DME 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.

Note: This "Durable Medical Equipment for Home Use" section applies to the following diabetes blood-testing

supplies and equipment and insulin-administration devices:

- For diabetes blood testing, 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

Diabetes urine-testing supplies and other insulin-administration devices are not covered under this "Durable Medical Equipment for Home Use" section (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section).

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 and classes 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 call 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 price of a hearing aid every 36 months when prescribed by a Plan Physician or 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 covered (or provided an Allowance for) 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.

Note: The following Services are not covered under this "Hearing Services" section:

- Hearing tests to determine the need for hearing correction (instead, refer to "Outpatient Care" in this "Benefits and Cost Sharing" section)
- Services related to the ear or hearing other than those related to hearing aids described in this section (instead, refer to the applicable heading in this "Benefits and Cost Sharing" section)
- Cochlear implants and osseointegrated external hearing devices (instead, refer to "Prosthetic and Orthotic Devices" in this "Benefits and Cost Sharing" section)

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
- 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
- Up to three visits per day
- Up to 100 visits per calendar year

Note: If a visit lasts longer than two hours, then each two-hour increment 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 inside California but within 15 miles or 30 minutes from our Service Area 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 (except for donor semen or eggs, and Services related to their procurement and storage)

Note: Outpatient drugs, supplies, and supplements are not covered under this "Infertility Services" section (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section).

Infertility Services exclusion

- Services to reverse voluntary, surgically induced infertility

Mental Health Services

We cover mental health Services as specified below, except that any outpatient visit limits specified in this section under "Outpatient mental health Services" and inpatient day limits specified in this section under "Inpatient psychiatric care" do not apply to the following conditions:

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

For all other mental health conditions, we cover evaluation, crisis intervention, and treatment only when a Plan Physician or other Plan Provider who is a mental health professional believes the condition will significantly improve with relatively short-term therapy.

Outpatient mental health Services

We cover:

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

You pay the following for these covered Services:

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

Inpatient psychiatric care

We cover psychiatric hospitalization in a Plan Hospital each calendar year. 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**.

Hospital alternative Services

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

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

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:

- Diagnostic and therapeutic imaging, such as X-rays, mammograms, and ultrasound: **no charge** except for certain imaging procedures that 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
- Magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET): **no charge**
- Nuclear medicine: **no charge**
- Laboratory tests (including screening tests for diabetes, cardiovascular disease, and cervical cancer, and tests for specific genetic disorders for which genetic counseling is available): **no charge**
- All other diagnostic procedures provided by Plan Providers who are not Plan Physicians (such as electrocardiograms and electroencephalograms): **no charge** except for certain diagnostic procedures that 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
- Radiation therapy: **no charge**
- Ultraviolet light treatments: **no charge**

Note: Services related to diagnosis and treatment of infertility are not covered under this "Outpatient Imaging, Laboratory, and Special Procedures" section (instead, refer to the "Infertility Services" section).

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 program:

- Items prescribed by Plan Physicians in accord with our formulary guidelines
- Items prescribed by the following Non–Plan Providers unless a Plan Physician determines that the drug, supply, or supplement 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 in conjunction with 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 "Requests for Payment" in the "Requests for Payment or Services" section)

How to obtain covered items

You must obtain covered drugs, supplies, and supplements from a Plan Pharmacy or through our mail order program 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 program, or through our Web site at **kp.org**. 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 program. 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 program 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 (such as nicotine patches) 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 (except for Single-source Generic Drugs):
  - **a $10 Copayment** for up to a 100 day supply
  - drugs prescribed for the treatment of sexual dysfunction disorders: **50% Coinsurance** for up to a 100 day supply
  - drugs for the treatment of infertility: **50% Coinsurance** for up to a 100 day supply
- Brand name items, compounded products, and Single-source Generic Drugs:
  - **a $20 Copayment** for up to a 100 day supply
  - drugs prescribed for the treatment of sexual dysfunction disorders: **50% Coinsurance** for up to a 100 day supply
  - drugs for the treatment of infertility: **50% Coinsurance** for up to a 100 day supply
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria) and elemental dietary enteral formula when used as a primary therapy for regional enteritis: **no charge** for up to a 30 day supply
- Emergency contraceptive pills: **no charge**
- Hematopoietic agents for dialysis: **no charge** for up to a 30 day supply
- Continuity drugs: If this *DF/EOC* is amended to exclude a drug that we have been covering and providing to you under this *DF/EOC*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the FDA at **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 IV drugs, supplies, and supplements

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

at **no charge**. Note: Injectable drugs, insulin, and drugs for the diagnosis and treatment of infertility are not covered under this paragraph (instead, refer to the "Outpatient drugs, supplies, and supplements" paragraph).

Diabetes urine-testing supplies and insulin-administration devices

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

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

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

Day supply limit

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 or 100 day supply for you. Upon payment of the Cost Sharing specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, you will receive the supply prescribed up to the day supply limit also specified in this section. The day supply limit is either a 30 day supply in a 30 day period or a 100 day supply in a 100 day period. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantities that exceed the day supply limit. Note: We cover episodic drugs prescribed for the treatment of sexual dysfunction disorders up to a maximum of 8 doses in any 30 day period or up to 27 doses in any 100 day period.

The pharmacy may reduce the day supply dispensed at the Cost Sharing indicated 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 comprised of Plan Physicians, selects drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature. The Pharmacy and Therapeutics Committee meets quarterly to consider additions and deletions based on new information or drugs that become available. If you would like to request a copy of our drug formulary, please call our Member Service Call Center. 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.

Note: The following Services are not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section:

- Durable medical equipment used to administer drugs (instead, refer to "Durable Medical Equipment for Home Use" in this "Benefits and Cost Sharing" section)
- Outpatient administered drugs (instead, refer to "Outpatient Care" in this "Benefits and Cost Sharing" section)
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (instead, refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care" in this "Benefits and Cost Sharing" section)

Outpatient prescription drugs, supplies, and supplements exclusions

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

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. Also, 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, cochlear implants, osseointegrated external hearing devices, and hip joints, that are approved by the federal Food and Drug Administration for general use.

External devices

We cover the following external prosthetic and orthotic devices, including repair and replacement of covered devices, at **no charge**:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx
- 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 Provider who is a podiatrist, physiatrist, or orthopedist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Other covered prosthetic and orthotic devices:
  - prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity
  - rigid and semi-rigid orthotic devices required to support or correct a defective body part
  - covered special footwear for foot disfigurement due to disease, injury, or developmental disability

Note: Hearing aids (other than internally implanted devices described in this section) are not covered under this "Prosthetic and Orthotic Devices" section (instead, refer to "Hearing Services" in this "Benefits and Cost Sharing" section).

Prosthetic and orthotic devices exclusions

- Dental appliances
- 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
- Electronic voice-producing machines
- 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**

Note: The following Services are not covered under this "Reconstructive Surgery" section:

- Outpatient laboratory and imaging Services (instead, refer to "Outpatient Imaging, Laboratory, and Special

Procedures" in this "Benefits and Cost Sharing" section)

- Outpatient prescription drugs (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section)
- Outpatient administered drugs (instead, refer to "Outpatient Care" in this "Benefits and Cost Sharing" section)
- Prosthetics and orthotics (instead, refer to "Prosthetic and Orthotic Devices" in this "Benefits and Cost Sharing" section)
- Transgender surgery (instead, refer to "Transgender Surgery" in this "Benefits and Cost Sharing" section)

Reconstructive surgery exclusions

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

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 *DF/EOC* 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 these covered Services, 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
- Services associated with the provision of drugs or devices that have not been approved by the federal Food and Drug Administration

Skilled Nursing Facility Care

Inside our Service Area, we cover at **no charge** up to 100 days per calendar year (including any days we covered under another 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 DME 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

Note: Outpatient imaging, laboratory, and special procedures are not covered under this section (instead, refer to "Outpatient Imaging, Laboratory, and Special Procedures" in this "Benefits and Cost Sharing" section).

Transgender Services

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**

Note: The following Services are not covered under this "Transgender Surgery" section:

- Outpatient prescription drugs (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section)
- Outpatient administered drugs (instead, refer to "Outpatient Care" in this "Benefits and Cost Sharing" section)
- Psychological counseling (instead refer to "Mental Health Services" in this "Benefits and Cost Sharing" section)
- Outpatient laboratory and imaging Services (instead, refer to "Outpatient Imaging, Laboratory, and Special Procedures" in this "Benefits and Cost Sharing" section)

Transgender Services exclusion

- Surgery or other Services that are intended primarily to change or maintain your appearance, voice, or other characteristics, except for the covered transgender services listed above.

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**.

Note: The following Services are not covered under this "Transplant Services" section:

- Outpatient laboratory and imaging Services (instead, refer to "Outpatient Imaging, Laboratory, and Special Procedures" in this "Benefits and Cost Sharing" section)
- Outpatient prescription drugs (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section)
- Outpatient administered drugs (instead, refer to "Outpatient Care" in this "Benefits and Cost Sharing" section)

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 *DF/EOC*. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits and Cost Sharing" section.

Certain exams and Services

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

Chiropractic Services

Chiropractic Services and the Services of a chiropractor.

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), donor semen or eggs (and Services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

Cosmetic Services

Services that are intended primarily to change or maintain your appearance, except for Services covered under "Reconstructive Surgery," "Transgender Services," and prostheses needed after a mastectomy covered under "Prosthetic and Orthotic Devices" in the "Benefits and Cost Sharing" section.

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 diapers, underpads, and other incontinence supplies, bandages, gauze, tape, antiseptics, dressings, and Ace-type bandages.

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 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.

Routine foot care Services

Routine foot care Services that are not Medically Necessary.

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except 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 *DF/EOC*, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor disputes. Under these extreme circumstances, if you have an Emergency Medical Condition, go to the nearest hospital as described under "Emergency Care" in the "Emergency, 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 Service are listed in the description of that Service in the benefit description in the "Benefits and Cost Sharing" section.

Coordination of Benefits (COB)

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

If both 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 COB rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." The secondary coverage may reduce its payment to take into account payment by the primary coverage. You must give us any information we request to help us coordinate benefits.

If your coverage under this *DF/EOC is* secondary, we may be able to establish a Benefit Reserve Account for you. You may draw on the Benefit Reserve Account during 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 COB, 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 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:

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

Southern California Region Members:

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

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay us directly. You 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:

Kaiser Permanente
Special Recovery Unit
Parsons East, Second Floor
P.O. Box 7017
Pasadena, CA 91109-9977
Attention: Third Party Liability Supervisor

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy arrangements" section and to satisfy those rights. You 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

Requests for Payment or Services

Requests for Payment

Emergency, Post-stabilization, or Out-of-Area Urgent Care

If you receive Emergency Care, Post-stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider as described in the "Emergency, Post-stabilization, and Out-of-Area Urgent Care from Non–Plan Providers" section, you must pay for the Services unless the Non–Plan Provider agrees to bill us. If you want us to pay for the Services, you must file a claim. Also, if you receive Services from a Plan Provider that are prescribed by a Non–Plan Provider in conjunction with covered Emergency, Post-stabilization, and Out-of-Area Urgent Care, you may be required to pay for the Services and file a claim. We will reduce any payment we make to

you or the Non–Plan Provider by the applicable Cost Sharing.

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

If our decision is not fully in your favor, we will tell you the reasons and how to file a grievance.

How to file a claim. To file a claim, this is what you need to do:

- As soon as possible, request our claim form by calling our Member Service Call Center at 1-800-464-4000 or 1-800-390-3510 (TTY 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 the Services, you must send us our completed claim form for reimbursement. Please attach any bills and receipts from the Non–Plan Provider
- To request that a Non–Plan Provider be paid for Services, you must send us our completed claim form and include any bills from the Non–Plan Provider. If the Non–Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If you later receive any bills from the Non–Plan Provider for covered Services other than your Cost Sharing amount, please call our Member Service Call Center at 1-800-390-3510 for assistance
- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled. For example, we may require documents such as travel documents or original travel tickets to validate your claim
- The completed claim form must be mailed to the following address as soon as possible after receiving the care. Any additional information we request should also be mailed to this address:

Northern California Region Members:

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

Southern California Region Members:

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

Other Services

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

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

If we do not approve your request, we will tell you the reasons and how to file a grievance.

Requests for Services

Standard decision

If you have received a written denial of Services from the Medical Group or a "Notice of Non-Coverage" and you want to request that we cover the Services, you must file a grievance as described in the "Dispute Resolution" section within 180 days of the date you received the denial.

If you haven't received a written denial of Services, you may make a request for Services orally or in writing to your local Member Services Department at a Plan Facility. You will receive a written decision within 15 days unless you are notified that additional information is needed. The additional information must be received within 45 days of the request for information in order for it to be considered in the decision. You will receive a written decision within 15 days after we receive the additional information. If you don't supply the additional

information within 45 days of the request, you will receive a written decision no later than 75 days after the date you made your request to Member Services. If we do not approve your request, we will send you a written decision that tells you the reasons and how to file a grievance.

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

Expedited decision

You or your physician may make an oral or written request that we expedite our decision about your request for Services 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 at 1-888-987-7247 (TTY 711), which is available seven days a week during business hours. After hours, you may leave a message and a representative will return your call the next day
- Send your written request to:
  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 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 request for Services as described under "Standard decision." If we do not approve your request, we will send you a written decision that tells you the reasons and how to file a grievance.

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 Department of Managed Health Care (DMHC) directly at any time without first filing a grievance with us.

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. 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:

- To a Member Services representative at your local Member Services Department at a Plan Facility (please refer to *Your Guidebook* for locations), or by calling our Member Service Call Center
- Through our Web site at **kp.org**

To the following location for claims described under "Emergency, Post-stabilization, and Out-of-Area Urgent Care" under "Requests for Payment" in the "Requests for Payment or Services" section:

Northern California Region Members:
Kaiser Permanente
Special Services Unit
P.O. Box 23280
Oakland, CA 94623

Southern California Region Members:
Kaiser Permanente
Special Services Unit
P.O. Box 7136
Pasadena, CA 91109

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 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).

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

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

- Call our Expedited Review Unit at 1-888-987-7247 (TTY 711), which is available seven days a week during business hours. After hours, you may leave a message and a representative will return your call the next day
- Send your written request to:
  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 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 DMHC directly at any time 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 children, except that they must appoint you as their authorized representative if they have the legal right to control release of information that is relevant to the grievance
- You may file for your ward if you are a court-appointed guardian
- You may file for your conservatee if you are a court-appointed conservator
- You may file for your principal if you are an agent under a health care proxy, to the extent provided under state law
- Your physician may request an expedited grievance as described under "Expedited grievance" in this "Dispute Resolution" section

DMHC 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 at **(1-800-464-4000)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the

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

Independent Medical Review (IMR)

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

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

- One of these situations applies to you:
  - 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 DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function

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

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

Experimental or investigational denials

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

- 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 *DF/EOC*. Such retroactive application shall be binding only on the Kaiser Permanente Parties.

Scope of Arbitration

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

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *DF/EOC* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. (Health Plan), including any claim for medical or hospital malpractice (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 or personal representative
- Any person claiming that a duty to him or her arises from a Member's relationship to one or more Kaiser Permanente Parties

"Kaiser Permanente Parties" include:

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

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

Initiating Arbitration

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

Serving Demand for Arbitration

Health Plan, KFH, KP Cal, TPMG, SCPMG, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

Northern California Region Members:

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

Southern California Region Members:

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

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

Filing Fee

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

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

Number of Arbitrators

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

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

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

Payment of 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 Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from our Member Service Call Center.

General Provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondents served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (i) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (ii) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the Neutral Arbitrator based on a showing of a good cause.

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

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

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

Termination of Membership

The University of California is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2007, your last minute of coverage was at 11:59 p.m. on December 31, 2006). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member if you receive any Services after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *DF/EOC* after your membership terminates, except as provided under "Payments after Termination" in this "Termination of Membership" section.

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, 2006, your termination date is January 1, 2007, and your last minute of coverage is at 11:59 p.m. on December 31, 2006.
For information about termination procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Employee

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

Retiree or Survivor

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

Family Member

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

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 knowingly commit fraud in connection with membership, Health Plan, or a Plan Provider. Some examples of fraud include:
  - misrepresenting eligibility information about you or a Dependent
  - presenting an invalid prescription or physician order
  - misusing a 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 except a Family Member who commits fraud or deception will be permanently deenrolled while any other Family Member and the Subscriber will be deenrolled for 12 months. If a Subscriber commits fraud or deception, the Subscriber and any Family Members will be deenrolled for 12 months. We may report fraud and other illegal acts to the authorities for prosecution.

Termination for Nonpayment

Nonpayment of Premiums

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

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

For Members who are eligible for Medicare as primary coverage, 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 A and B 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 Unit, we will terminate the memberships of everyone in the Family Unit in accord with this "Termination for Nonpayment" section.

Note: Medicare is the primary coverage except when federal law requires that your Group's health care plan 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 by law. If we discontinue offering a particular product in a market, we will terminate just the particular product upon 90 days prior written notice to you. If we discontinue offering all products to groups in a small or large group market, as applicable, we may terminate your Group's *Agreement* upon 180 days prior written notice to you.

Certificates of Creditable Coverage

The Health Insurance Portability and Accountability Act (HIPAA) requires employers or health plans to issue "Certificates of Creditable Coverage" to terminated group members. The certificate documents health care membership and is used to prove prior creditable coverage when a terminated member seeks new coverage. When your membership terminates, or at any time upon request, we will mail the certificate to you (the Subscriber) unless your Group has an agreement with us to mail the certificates. If you have any questions, please contact your Group's benefits administrator.

Payments after Termination

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

- Refund any amounts we owe the University of California 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 "Requests for Payment" in the "Requests for Payment or Services" section. 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 "DMHC Complaints" in the "Dispute Resolution" section).

Continuation of Membership

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

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 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.

Continuation of Group Coverage

COBRA

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

You must submit a COBRA election form to your Group within the COBRA election period. Please ask your Group's benefits administrator for details about COBRA coverage, such as how to elect coverage, how much you must pay your Group, and where to send your COBRA Premiums.

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 in "COBRA Extension (Cal-COBRA)" below.

COBRA extension (Cal-COBRA)

In certain cases, if you would otherwise lose COBRA coverage, you may be able to continue uninterrupted Group coverage under this *DF/EOC* for a limited time upon arrangement with us in compliance with Cal-COBRA 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 pay us the monthly premiums by the billing due date described under "How to request Cal-COBRA enrollment and paying premiums"

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.

How to request Cal-COBRA enrollment and paying premiums. To request an enrollment application, please call our Member Service Call Center. Within 10 days of your request, we will send you our enrollment application, which will include premiums and billing information. You must return your completed enrollment 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 a bill 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 when you exhausted COBRA coverage 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.

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)
- Expiration of 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 or State Continuation Coverage 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: (i) expiration of 36 months after your original COBRA effective date, or (ii) the first day of the first month following 31 days after Social Security issued its final determination. You must notify us within 30 days after you receive Social Security's final determination that you are no longer disabled.

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, if your Group terminates its agreement with the health plan you are enrolled in. You will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA.

To continue your Cal-COBRA coverage with us, we must receive your enrollment application during your Group's open enrollment period, or within 63 days of receiving the termination notice described below from your Group. 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 below from your Group. 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.

Note: 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 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.

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

Leave of Absence, Layoff, or Retirement

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

State Continuation Coverage

New enrollments are no longer available for State Continuation Coverage under Section 1373.621 of the California Health and Safety Code. If you are already enrolled in State Continuation Coverage, your coverage terminates on the earliest of:

- The date your Group's *Agreement* with us terminates
- The date you obtain coverage under any other group health plan not maintained by your Group, regardless of whether that coverage is less valuable
- The date you become entitled to Medicare
- Your 65th birthday
- Five years from the date your COBRA or Cal-COBRA coverage was scheduled to end, if you are a Subscriber's Spouse or former Spouse
- The date your membership is terminated for nonpayment of premiums as described under "Termination for nonpayment of Cal-COBRA or State Continuation Coverage premiums" in this "Continuation of Membership" section

Termination for nonpayment of Cal-COBRA or State Continuation Coverage premiums

If we do not receive your entire premium payment on or before the last day of the month preceding the month of coverage, then coverage for you and all your Dependents will end retroactively back to 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 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's address of record. 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 your membership for nonpayment if we do not receive the required premiums within 15 days from the date the notice confirming termination of membership was mailed
- The specific date and time when coverage for you and all of your Dependents will end if we do not receive the premiums

We will terminate your membership if we do not receive payment within 15 days of the date we mailed you 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 your membership for nonpayment of premiums
- The specific date and time when coverage for you and all your Dependents ended
- Information explaining whether or not you can reinstate your membership

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.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this *DF/EOC* for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. 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 *DF/EOC* 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, USERRA, or State Continuation Coverage after COBRA or Cal-COBRA coverage, you may be eligible to enroll in our Individual–Conversion Plan when your Group continuation coverage ends. The premiums and coverage under our Individual–Conversion Plan are different from those under this *DF/EOC*.

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, USERRA, or State Continuation Coverage after COBRA or Cal-COBRA 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.

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 *DF/EOC.*

Advance directives

The California Health Care Decision Law offers several ways for you to control the kind of health care you will receive if you become very ill or unconscious, including 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 *DF/EOC*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *DF/EOC*.

Amendment of *Agreement*

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

Assignment

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

Attorneys' fees and expenses

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

Governing law

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

Group and Members not our agents

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

Health Insurance Counseling and Advocacy Program (HICAP)

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

Named fiduciary

Under the University of California *Group Agreement*, we have assumed the role of a "named fiduciary," a party responsible for determining whether you are entitled to benefits under this *DF/EOC*. Also, as a named fiduciary, we have the discretionary authority to review and evaluate claims that arise under this *DF/EOC*. We conduct this evaluation independently by interpreting the provisions of this *DF/EOC*.

No waiver

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

Nondiscrimination

We do not discriminate in our employment practices or in the delivery of Services on the basis of age, race, color, national origin, cultural background, religion, sex, sexual orientation, or physical or mental disability.

Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call our Member Service Call Center 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 *DF/EOC* or provide your Group other information that affects you, your Group is required to notify the Subscriber within 30 days (or five days if we terminate your Group's *Agreement*) after receiving the information from us.

Other formats for Members with disabilities

You can request a copy of this *DF/EOC* 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 (PHI). We also require contracting providers to protect your PHI. PHI is health information that includes your name, Social Security number, or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

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

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* describing our policies and procedures for preserving the confidentiality of medical records and other PHI is available and will be furnished to you upon request. To request a copy, please call our Member Service Call Center. You can also find the notice at your local Plan Facility or on our Web site at **kp.org.**

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

By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the Group Hospital and Professional Service Agreement. What is written in this document does not constitute a guarantee of plan

coverage or benefits—particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

This section describes how the Plan is administered and what your rights are.

Sponsorship and Administration of the Plan

The University of California is the Plan sponsor and administrator for the Plan described in this booklet. If you have a question, you may direct it to:

University of California
Human Resources and Benefits
Health & Welfare Administration
300 Lakeside Drive, 12th Floor
Oakland, CA 94612
1-800-888-8267

Retirees may also direct questions to the University's Customer Service Center at the above phone number.

Claims under the Plan are processed by Kaiser Foundation Health Plan, Inc., at the following locations:

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

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

Group Contract Numbers

Northern California Region

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

Southern California Region

The Group contract numbers for the University of California, Southern California Region, are 102601, 102602, 102603, 102604, 102605, 102607, 102608, 102609, 102610, 102611, 102624, and 102625.

Type of Plan

This Plan is a health and welfare plan that provides group medical care benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

Plan Year

The plan year is January 1 through December 31.

Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all Employees, Retirees, and Plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums, and what portion of the premiums the University will pay. The portion of the premiums that the University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.

Financial Arrangements

The benefits under the Plan are provided by Kaiser Foundation Health Plan, Inc., under a Group Service Agreement. The 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 *DF/EOC*.

Nondiscrimination Statement

In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity employer.

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to:

Director of Diversity and Employee Programs
University of California
Office of the President
300 Lakeside Drive
Oakland, CA 94612

and for faculty to:

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

KAISER PERMANENTE.

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

kaiserpermanente.org

Member and Marketing Communications
4309-0003-04-r02