KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Electronic Documents Policy

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

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

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

These electronic documents may be posted to Purchaser Web sites.

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

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

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

Kaiser Foundation Health Plan, Inc.
California Division

KAISER PERMANENTE®

# Kaiser Permanente Combined Disclosure Form and Evidence of Coverage for the University of California

**Effective January 1, 2003**

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

EFFECTIVE JANUARY 1, 2003

# Kaiser Permanente Combined Disclosure Form and Evidence of Coverage for the University of California

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## Introduction

When you join Kaiser Permanente, you have plenty of reasons to feel good about your health care coverage. Our physicians are some of the most qualified in the nation. Most Permanente physicians are board certified, and some teach in the country's top universities. You also have access to specialists in almost every field of medicine and can self-refer to selected specialties. Our preventive care programs and classes can teach you and your family great ways to stay healthy.

You may receive care from any one of our locations. Plan Hospitals are open seven days a week and provide 24-hour emergency care. Many of our Plan Medical Offices provide same-day urgent care and evening and weekend appointments.

As a Kaiser Permanente Member, you get the advantage of a nationally renowned, nonprofit health plan. Whatever your needs—from a routine checkup to emergency care to health care for your children—you can rely on America's largest nonprofit HMO to provide the quality service you deserve.

This *Combined Disclosure Form and Evidence of Coverage for the University of California (DF/EOC)* is divided into the following parts: "Section One, Traditional Plan" applies to Members enrolled in the Kaiser Permanente Traditional Plan, a non-Medicare plan; "Section Two, Senior Advantage Plan" applies to Members enrolled in the Kaiser Permanente Senior Advantage Plan, a managed Medicare plan; and "Section Three, General Information for All Members" provides information that is common for Members of both the Traditional and Senior Advantage Plans. Each section is clearly marked at the top of each page.

Included are "Benefit Summary and Copayments" charts for the Traditional and the Senior Advantage Plans, with comprehensive benefit descriptions that follow. The Traditional Plan "Benefit Summary and Copayments" chart is on pages 10 through 14. The Senior Advantage Plan "Benefit Summary and Copayments" chart is on pages 72 through 76.

SECTION ONE

# Kaiser Permanente Traditional Plan

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*Kaiser Permanente*

*Combined Disclosure Form and*

*Evidence of Coverage*

*for the*

*University of California*

*Effective January 1, 2003*

**Member Service Call Center**
**1-800-464-4000**
**7 a.m. to 7 p.m., seven days a week**

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

***www.kaiserpermanente.org***

SECTION ONE

# Kaiser Permanente Traditional Plan

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# Traditional Plan Summary of Changes Effective January 1, 2003

Unless otherwise indicated, effective January 1, 2003, the following is a summary of the most important changes and clarifications that will apply to your Traditional Plan coverage for the year 2003:

### Allergy testing visit Copayment

The allergy testing visit Copayment will equal the office visit Copayment of $10. It was previously $5.

**Note:** The allergy injection visit Copayment will remain at $5.

### Clinical Trials

The "Services associated with Clinical Trials" section has been added to the "Benefits" section of the *DF/EOC*.

### Drugs, supplies, and supplements

- Smoking-cessation drugs will no longer be limited to one course of treatment per year. They will be provided at the Copayment when Medically Necessary and when taken in conjunction with smoking-cessation behavioral modification health classes.
- Emergency contraceptive pills will be provided at no charge.
- Drugs to shorten the duration of the common cold will not be covered.
- Requested special packaging (such as dose packaging) of drugs will not be covered.
- A 50-percent Copayment will apply to excluded drugs that Health Plan is required to provide under Prescription Continuity Coverage (California Health and Safety Code, Section 1367.22).
- Drugs in short supply from the manufacturer will be limited to less than a 100-day supply at the drug Copayment.
- Compounded drug products listed on our drug formulary, or that include ingredients requiring a prescription by law, will be provided at the brand name, $20 Copayment.

### Emergency Care Services

"Emergency Care Services" has been revised in the "Benefits" section. A separate "Emergency, urgent, and routine care" section has been added to the "How to Obtain Services" section.

### Post-Stabilization Care

The Traditional Plan does not cover care received from non-Plan Providers after the Member could, without medically harmful results, be moved to a facility we designate (this is known as Post-Stabilization Care). In the past, Health Plan has not always enforced this provision. Beginning January 1, 2003, this provision will be enforced unless we authorize the Post-Stabilization Care.

### Residence in a non-California service area

Members who live or move to the service area of a Health Plan Region outside of California are not eligible for California membership. Members will be terminated effective on the group's renewal date. Members may be able to enroll in the new service area if there is an agreement with their group in that area. (Eligibility requirements, benefits, Dues, and Copayments may not be the same in the other service area.) This restriction does not apply to COBRA or USERRA Members, the Subscriber's or the Subscriber's Spouse's children who are attending an accredited college or vocational school, or a Dependent the Subscriber or Spouse is required to cover pursuant to a Qualified Medical Child Support order.

### Senior Advantage capacity limitation

We will not be able to enroll new Members into the Kaiser Permanente Senior Advantage Plan if the applicant isn't already a Member and resides in an area that is subject to a capacity limitation approved by the Centers for Medicare & Medicaid Services (CMS). This limitation does not apply to enrolled Members who are newly eligible for Medicare, including when they turn 65.

### Exclusions

- A "Hair loss or growth treatment" exclusion has been added.
- The "Dental care" exclusion has been revised to indicate that certain dental Services to prepare the jaw or jawbone for radiation treatment are covered.
- The "Experimental or investigational Services" exclusion does not apply to "Clinical Trials."
- The "Custodial care" exclusion does not apply to "Hospice care."

### Health education classes

Certain health education classes will be covered at no charge. These classes were previously provided for a reasonable charge or at the office visit Copayment.

**Hospice care** in the "Benefits" section of this *DF/EOC* has been revised to comply with state law (AB 892).

### Vision Services

For Medicare Part B Members who have assigned their benefits to Kaiser Permanente, the post-cataract surgery eyewear allowance has changed to **$150 per eye, per lifetime.**

### Administrative fee for billing for Copayments

Copayments are due when Health Plan provides Services or supplies to Members. The fee associated with billing Members for Copayments is increasing to $13.50 to reflect the actual cost of our billing process. It was previously $5.

### Dispute resolution

The "Dispute resolution" section has been revised for clarity.

### Binding arbitration

The "Binding arbitration" section has moved from "Section Three" and is included in the "Dispute resolution" section.

### Confidentiality

The "Medical confidentiality" section in "Section Three, Miscellaneous Provisions" has been revised and is now titled "Privacy practices."

### Notice to new enrollees about continuity of care

The "Notice to new enrollees about continuity of care" section has been revised to include acute, serious, or chronic psychiatric conditions.

### Terminology changes

A number of terms used in this *DF/EOC* have been added to the "Definitions" in "Section Three" for clarity.

# Benefit Summary and Copayments

This section lists Kaiser Permanente Traditional Plan Copayments only. It does not describe benefits. To learn what is covered for each benefit (including exclusions and limitations), please refer to the identical heading in the "Benefits" section (also refer to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section, which applies to all benefits).

### Copayments

Maximum Copayment limit for the 2003 calendar year:

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

| *Category* | *Copayment* |
|---|---|
| **Hospital inpatient care** | |
| Inpatient Services | $250 per admission |
| **Outpatient care** | |
| Primary and specialty care visits | $10 per visit |
| Allergy testing visits | $10 per visit |
| Allergy injection visits | $5 per visit |
| Blood and blood products | No charge |
| Immunization/Inoculation | No charge |
| Gynecological visits | $10 per visit |
| Scheduled prenatal care and the first postpartum visit | No charge |
| Pediatric visits | $10 per visit |
| Well-child preventive care visits (age 23 months or younger) | No charge |
| Routine physical exams | $10 per visit |
| Outpatient surgery | $10 per procedure |
| **Ambulance Services** | |
| | No charge |
| **Chemical dependency Services** | |
| Inpatient detoxification | $250 per admission |
| Outpatient individual therapy | $10 per visit |
| Outpatient group therapy | $5 per visit |
| Transitional residency recovery Services (up to 60 days per calendar year, not to exceed 120 days in any 5-year period) | $100 per admission |

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

**Note:** *Quantities that exceed any supply maximum will be provided at the Charges.*
**Limitation:** *The day supply dispensed at the Copayment may be reduced (a) to a 30-day supply in any 30-day period for specific drugs (please call our Member Service Call Center for the current list of these drugs), or (b) if the pharmacy limits the amount dispensed because the drug is in limited supply in the market.*

| *Category* | *Copayment* |
|---|---|
| **Durable medical equipment (DME)** | |
| Durable medical equipment used during a covered stay in a Plan Hospital or Skilled Nursing Facility | No charge |
| Durable medical equipment used in the home | No charge |
| **Emergency Department visits** | |
| | $50 per visit* |
| *Copayment waived if directly admitted to a hospital. | |
| **Family planning Services** | |
| Inpatient Services | $250 per admission |
| Outpatient visits | $10 per visit |
| **Health education** | |
| Individual visits | $10 per visit |
| All other covered Services | No charge |
| **Hearing Services** | |
| Hearing test | $10 per visit |
| Hearing aid(s) every 36 months, as described in the "Benefits" section | Up to a $1,000 allowance per aid, per ear |
| **Home health care** | |
| | No charge |
| **Hospice care** | |
| | No charge |
| **Imaging, laboratory, and special procedures** | |
| | No charge |

| *Category* | *Copayment* |
|---|---|
| **Infertility Services** | |
| Inpatient Services | 50% of Charges |
| Outpatient visits | 50% of Charges |
| Imaging, laboratory, and special procedures | 50% of Charges |
| Prescribed drugs obtained at Plan Pharmacies | 50% of Charges |
| **Mental health Services** | |
| Inpatient Services | $250 per admission |
| Outpatient visits | $10 per visit |
| **Ostomy and urological supplies** | |
| | No charge |
| **Physical, occupational, and speech therapy, and multidisciplinary rehabilitation Services** | |
| Inpatient Services | No charge |
| Outpatient visits | $10 per visit |
| **Prosthetic and orthotic devices** | |
| Covered devices as described in the "Benefits" section | No charge |
| **Reconstructive surgery** | |
| Inpatient Services | $250 per admission |
| Outpatient visits | $10 per visit |
| Outpatient surgery | $10 per procedure |
| **Services associated with Clinical Trials** | |
| The Copayment that would apply if the Services were not provided in connection with a Clinical Trial | |
| **Skilled Nursing Facility care** | |
| (for up to 100 days per calendar year) | No charge |

| *Category* | *Copayment* |
|---|---|
| **Transplant Services** | |
| Inpatient Services | $250 per admission |
| Outpatient visits | $10 per visit |
| **Urgent care** | |
| In-area | $10 per visit at a Plan Facility; not covered at a non-Plan Facility |
| Out-of-area | $10 per visit if seen in a physician's office; $50 per visit when seen in the emergency room at a non-Plan Facility |
| **Vision Services** | |
| Eye refraction exam to determine the need for vision correction | $10 per visit |

# Welcome to Kaiser Permanente

Kaiser Permanente, a federally qualified health maintenance organization (HMO), provides health care Services to its Members using physicians and facilities located within a specific geographic area. Kaiser Permanente is one of the largest HMOs in the country. We are dedicated to providing our Members with quality health care at an affordable cost.

Kaiser Permanente of California has two Service Areas: the Northern California Service Area and the Southern California Service Area. Please refer to the "Service Area" section in "Section Three, General Information for All Members" of this booklet to determine which Service Area you will be enrolled in.

### About this *Disclosure Form and Evidence of Coverage*

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

The term of this *DF/EOC* is from January 1, 2003, to December 31, 2003. Your group's benefits administrator can confirm that this *DF/EOC* is still in effect and can provide you with a current one if this *DF/EOC* has expired.

Health Plan provides Services directly to our Members through an integrated medical care system, rather than reimbursing expenses on a fee-for-service basis. This *DF/EOC* should be read with this direct-service nature in mind.

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

Please keep this booklet. If you enroll with Kaiser Permanente, it becomes your *Disclosure Form and Evidence of Coverage (DF/EOC).*

- 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 read the applicable sections carefully.

***Note: By enrolling with Health Plan, you are agreeing to have certain disputes decided by binding arbitration, as specified in the "Binding arbitration" section. Both Health Plan and Health Plan Members give up all rights to a jury or court trial for these disputes.***

### A special note for Members with Medicare and Annuitants

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

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

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

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

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

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

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

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

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

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

### Relationships among parties affected by this *Disclosure Form and Evidence of Coverage*

The Northern California Region contracts with The Permanente Medical Group, Inc., and Kaiser Foundation Hospitals, which are major providers of Services for Members. The Southern California Region contracts with the Southern California Permanente Medical Group and Kaiser Foundation Hospitals to provide your care. In some communities, Permanente physicians, in conjunction with community physicians practicing in the major medical specialties, work together with the authorized local hospitals and support Services to serve your health care needs.

Our contracts with The Permanente Medical Group, Inc., the Southern California Permanente Medical Group, Kaiser Foundation Hospitals, and any other contracting provider state that you are not liable for any amounts owed by us to that provider. If you obtain Services from any non-contracting provider, you may be liable for the cost of any Services we do not pay.

Plan Physicians maintain the physician-patient relationship with Members and are solely responsible to Members for all medical Services. Kaiser Foundation Hospitals maintain the hospital-patient relationship with Members and are solely responsible to Members for all hospital Services.

We will notify you in writing within a reasonable time if Kaiser Foundation Hospitals, Medical Group, or any other contracting provider terminates or breaches its contract with us or is unable to perform its duties under its contracts with us, if you might be materially and adversely affected by such an event.

The interpretation of this *Disclosure Form and Evidence of Coverage* is guided by the direct-service nature of the Kaiser Permanente Medical Care Program. If we make a favorable exception to the terms and conditions of the *Group Agreement* or your benefits for you or any other Member, we are not required to make the same or similar exceptions for you or any other Member in the future.

## Who is eligible

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

- **Group eligibility requirements**
  You must meet your group's eligibility requirements that we have approved. Your group is required to inform Subscribers of its eligibility requirements.
- **Service Area eligibility requirements**
  The Subscriber must live in our Service Area at the time he or she enrolls. Our Service Area is described in the "Service Area" section of "Section Three, General Information for All Members." A Subscriber or Dependent cannot enroll or continue enrollment if he or she lives in or moves to a "non-California Region's service area" 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 go to a Plan Facility to receive covered Services, except as described in the "Emergency, urgent, and routine care" section about Emergency Care and Out-of-Area Urgent Care received from non-Plan Providers and in "Our visiting member program" in the "How to Obtain Services" section.

**Non-California Region's service area.** If you live in or move to the service area of a Region outside of California, you are not eligible for membership under this *DF/EOC* (unless you are one of the exceptions listed below). You should contact your group's benefits administrator to learn about your group health care options. You may be able to enroll in the new service area if there is an agreement with your group in that area. However, eligibility requirements, benefits, Dues, and Copayments may not be the same in the other service area.

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

- Members who are eligible under this *DF/EOC* because of COBRA or USERRA coverage (please refer to the "Termination of Membership" section for information about COBRA and USERRA coverage).
- The Subscriber's or the Subscriber's Spouse's children who are attending an accredited college or vocational school.
- A Dependent the Subscriber or Subscriber's Spouse is required to cover pursuant to a Qualified Medical Child Support Order.

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

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

## ■ Subscriber

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

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

These conditions apply, provided:

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

## ■ Eligible Dependents

**Spouse:** Your legal Spouse. Except if you are a Survivor Annuitant, you may not enroll your legal Spouse.

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

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

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

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

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

Your signature on the Health Plan-approved enrollment form or, if you enroll electronically, then your electronic enrollment, attests to these conditions in (a), (b), and (c) above. You will be asked to submit a copy annually

of your federal income tax return (IRS form 1040 or IRS equivalent showing the covered Dependents and your signature) to the University to verify income tax dependency.

Any unmarried child, as defined above (except a child for whom you are the legal guardian), who is incapable of self-sustaining employment due to a physical or mental handicap may continue to be covered past age 23 provided: The child is dependent upon you for at least 50 percent of his or her support, is your Dependent for income tax purposes, the incapacity began before age 23, the child was enrolled in a medical plan before age 23, and coverage is continuous. Application must be made to Kaiser Permanente 31 days prior to the child's 23rd birthday and is subject to approval by the Plan. Kaiser Permanente may periodically request proof of continued disability. Your signature on the enrollment form or, if you enroll electronically, then your electronic enrollment, attests to these conditions. You will be asked to submit a copy annually of your federal income tax return (IRS form 1040 or IRS equivalent showing the covered Dependent and your signature) to the University to verify income tax dependency.

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

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

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

**Other eligible Dependents:** You may enroll an adult Dependent relative or same-sex domestic partner and their eligible children as set forth in the University of California Group Insurance Regulations. For information on who qualifies and on the requirements to enroll an adult Dependent relative or same-sex domestic partner, contact your local Benefits Office.

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

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

**Note:** If necessary to maintain satisfactory service to existing Members, Kaiser Permanente may suspend enrollment of additional Members (except for newly eligible Spouse, newborns, newly eligible stepchildren, or newly adopted children and Senior Advantage enrollees).

## ■ Persons terminated for cause or nonpayment

If you or a member of your Family Unit have ever had Services through Health Plan terminated for any of the reasons listed in "Termination for cause" and/or "Termination for nonpayment" in the "Termination of Membership" section, you or the affected member in your Family Unit may not be eligible to enroll.

## Enrollment

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

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

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

a. For a new Spouse, eligibility begins on the date of marriage. Survivor Annuitants may not add new Spouses to their coverage.

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

c. For newly adopted children, eligibility begins on the earlier of:

   i. The date the employee or the employee's Spouse has the legal right to control the child's health care, or

   ii. The date the child is placed in the employee's physical custody.

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

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

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

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

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

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

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

An employee who currently has two or more covered Dependents may add a newly eligible Dependent after the PIE. Retroactive coverage for such enrollment is limited to the later of:

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

b. The date the Dependent became eligible.

## Special enrollment due to loss of other coverage

An employee and the employee's eligible Dependents may enroll within 30 days of losing other coverage by submitting to your group an enrollment or change of enrollment

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

The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date that the enrollment form or the change of enrollment form is signed.

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

## Special enrollment due to new Dependents

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

The effective date of an enrollment resulting from marriage is no later than the first day of the month following the date that an enrollment or change of enrollment form is signed. Enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, adoption, or placement for adoption.

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

## Effective date of coverage

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

Coverage for newly eligible Dependents is effective on the date the Dependent becomes eligible, provided they are enrolled (either by receipt of an enrollment form by the local Accounting or Benefits Office or by electronic enrollment) within the PIE. There is one exception to this rule: Coverage for a newly eligible adopted child enrolling during the additional PIE is effective on the date the adoption becomes final.

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

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

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

## Notice to new enrollees about continuity of care

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

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

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

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

## Dues

Members are entitled to health care coverage only for the period for which we receive the appropriate Dues from the University. If you are responsible for any contribution of the Dues, the University will tell you the amount and how to pay the University (through payroll deduction, for example).

## Copayments

You may be required to pay Copayments for some Services. These are listed in the "Benefits" section. Copayments are due at the time of your visit or order date. In some cases, we may agree to bill you for your Copayment. If we agree to bill you, we will increase the Copayment by $13.50 and mail you a bill for the entire amount. Also, before you can schedule an elective infertility procedure, you must pay the Copayment for the procedure along with any past-due, infertility-related Copayments.

## Annual out-of-pocket maximum

There are limits to the total amount of Copayments you must pay in a calendar year for certain Services covered under this *DF/EOC*. The annual Copayment limits are $1,500 for one Member and $3,000 for a Subscriber and all of his or her Dependents.

- Ambulance Services;
- Home health care;
- Hospital care, including Emergency Department visits;
- Imaging, laboratory, and special procedures;
- Physical, occupational, respiratory, and speech therapy, and multidisciplinary rehabilitation Services; and
- Professional Services.

When you pay a Copayment for these Services, ask for and keep the receipt. When the receipts add up to the annual Copayment limit, call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** to find out where to submit your receipts. When you submit them, we will give you a card showing that you do not have to pay any more Copayments for the specified Services through the end of the calendar year.

# 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, Post-Stabilization, and urgent care" in the "Benefits" section;
- "Referrals to specialists" in this "How to Obtain Services" section; and
- "Our visiting member program" in this "How to Obtain Services" section.

Through our medical care program, you have access to the covered Services you may need, such as routine care with your own Plan Physician, hospital care, nurses, laboratory, and pharmacy Services, and other benefits described in the "Benefits" section.

## Using your identification card

Each Member has a Health Plan ID card with a Medical Record Number on it, which is useful when you call for advice, make an appointment, or go to a provider for covered care. The Medical Record Number is used to identify your medical records and membership information. You should always have the same Medical Record Number. Please let us know if we ever inadvertently issue you more than one Medical Record Number by calling our Member Service Call Center. If you need to replace your card, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

Your ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed for any Services we provide. If you let someone else use your card, we may keep your card and terminate your membership.

## Plan Facilities

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

Plan Medical Offices and Plan Hospitals are listed in *Your Guidebook to Kaiser Permanente Services. Your Guidebook* includes information about the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services.

***Notice to Southern California Members:***
Please be aware that if a covered Service is not available at a Plan Facility, it will be made available to you at another Plan Facility. However, in accord with state law, we are required to include the following statement: "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, the Medical Group, independent practice association, clinic, or call our Kaiser Permanente Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** to ensure that you can obtain the health care Services that you need."

## Your primary care Plan Physician

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

***Southern California Members*** residing in Coachella Valley and western Ventura County are required to select a primary care Plan Physician (Affiliated Physician). After enrollment, we will send a letter explaining how to select a primary care Affiliated Physician.

## Second opinions

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

- If you are unsure about whether a procedure that has been recommended by your Plan Physician is reasonable or necessary;
- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions;

- The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the Plan Physician is unable to diagnose the condition;
- The treatment plan in progress is not improving your medical condition within an appropriate period of time given the diagnosis and plan of care; or
- You have concerns about the diagnosis or plan of care.

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

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

***Northern California Members*** residing in Stanislaus County may arrange for a second medical opinion by a Plan Physician by calling our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

***Southern California Members,*** if you live in Coachella Valley or western Ventura County and wish to obtain a second opinion from another Affiliated Physician, your designated primary care Affiliated Physician must arrange the second medical opinion.

## Getting the care you need

You are covered for medical emergencies anywhere in the world. Emergency care is provided at Plan Hospitals 24 hours a day, seven days a week. If you think you have a medical or a psychiatric emergency, call 911 or go to the nearest hospital. For coverage information about out-of-Plan emergency care, refer to "Emergency, Post-Stabilization, and urgent care" in the "Benefits" section.

You may also obtain medical advice by telephone. Advice nurses are RNs specially trained to help assess medical problems and provide advice. They can help solve a problem over the phone and instruct you on self-care at home, if appropriate. If the problem is more severe and you need an appointment to be seen, they will help schedule one.

Refer to *Your Guidebook to Kaiser Permanente Services* for nonemergency appointment information. If you don't have *Your Guidebook,* call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week to request one.**

## Referrals to specialists

Plan Physicians offer primary medical, pediatric, obstetrics, and gynecology care as well as specialty care in areas such as surgery, orthopedics, cardiology, oncology, urology, and dermatology. A Plan Physician will refer you to a Plan specialist when appropriate. However, you can receive care from Plan Physicians in the following specialties without a referral: internal medicine, obstetrics/gynecology, family practice, pediatrics, optometry, psychiatry, and chemical dependency. Please refer to your facility's listing in *Your Guidebook* for the departments that do not require a referral.

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 review the request to determine if the Service is Medically Necessary and whether it is available from a Plan Provider. The Medical Group must authorize the referral in writing in order for us to cover the Services. Copayments for these referral Services are the same as those required for Services provided by a Plan Provider. Please refer to "Second opinions" in this section for information about obtaining a second opinion from a non-Plan Provider.

## Authorization procedure

Certain Services require prior authorization by the Medical Group for Services to be covered by us. If the Medical Group determines that the Services are Medically Necessary, then the Medical Group will authorize them. The Services for which prior authorization is required are the three listed below, and referrals to non–Plan Providers, which are described under "Referrals to specialists" above. For these Services, the applicable Medical Group designee will make the authorization decision within the time frame appropriate for the nature of your condition, but no later than five business days after receiving all the information reasonably necessary to make a decision, including information required from you, unless the request is for urgent Services, in which case the decision will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision. If we cannot meet these time frames because we don't have information reasonably necessary to make a decision about your request or because we have requested consultation by a particular physician who is an expert in the care you have requested, then we will inform you and your treating physician, in writing, that we will need more time to make this decision. We will inform you about the additional information we need or the type of expert we need to consult and the date we anticipate that we will make a decision about your request.

Decisions regarding requests for Services will be made only by licensed physicians or other appropriately licensed health care professionals. Any criteria we use to make the decision to authorize, modify, delay, or deny your request for Services will be available upon request.

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are Medically Necessary, 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 receive a written decision that explains the decision 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.

In addition to referrals to non–Plan Providers described under "Referrals to specialists" above, these Services require prior authorization by the Medical Group:

- **Transplants.** Written referrals from your Plan Physician for transplants will be decided by the Medical Group's regional transplant advisory committee or board if one exists. In cases where no transplant committee or board exists, the Medical Group will refer you to a transplant center for a determination. The center will approve the transplant if it is Medically Necessary.
- **Bariatric Surgery.** If your Plan Physician makes a written referral for bariatric surgery, the referral is reviewed by the Medical Group's regional Bariatric Medical Director or his or her designee, who will determine whether this Service is Medically Necessary in accordance with the bariatric surgery referral guidelines.

- **Durable Medical Equipment (DME).** If your Plan Physician prescribes DME, he or she will submit a written referral to the Plan Hospital's DME coordinator who will verify your DME coverage and determine whether your clinical condition meets the guidelines specified in our DME formulary. If your DME coverage includes the item, but your clinical condition does not appear to meet the guidelines specified by our DME formulary, then the DME Coordinator will contact the Plan Physician for additional information about the request. If the request still does not appear to meet our DME formulary guidelines, the request will be submitted to Medical Group's designee Plan Physician, who will determine whether the item is Medically Necessary.

This description is only a brief summary of the authorization procedure. For more information, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.** Please refer to the "Emergency Care" section for authorization requirements that apply to Post-Stabilization Care.

## Contracts with Plan Providers

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, including salary, capitation, per diem rates, case rates, fee for service, and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call our Member Service Call Center.

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

**Termination of a Plan Provider's contract.** If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care you receive from that provider, in excess of any applicable Copayments, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

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

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

The Services must otherwise be covered under this *DF/EOC*. Also, the terminated provider must agree in writing to our contractual terms and conditions and comply with them for Services to be covered by the Medical Group.

If you would like more information about this provision, or to make a request, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

## Our visiting member program

If you visit the service area of another Region temporarily (not more than 90 days), you can receive certain Services as a visiting member

from designated providers in that area. The covered Services, supplies, and Copayments may differ from those under this *DF/EOC* and are governed by our visiting member program. This program does not cover certain Services, such as transplants or infertility Services. Except for covered Emergency Care and Out-of-Area Urgent Care, your right to receive Services in the visited service area ends after 90 days, unless you receive prior written authorization from us to continue receiving covered Services in the visited service area.

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

## Moving outside our Service Area

If you are moving outside our Service Area, you can continue your membership (subject to your group's eligibility requirements). However, you must go to a Plan Facility to receive covered Services, except as described under "Emergency, Post-Stabilization, and urgent care" in the "Benefits" section and "Our visiting member program" in this "How to Obtain Services" section.

## Moving to another service area

If you move to the service area of another region, you should contact your group benefits administrator to learn about your group health care options. You may be able to continue or transfer your group membership if there is an arrangement with your group that permits membership in the new service area. However, the benefits, Copayments, Dues, and eligibility requirements may not be the same in the new service area. The service areas where you may apply and enroll can change at any time. Consult with your local Benefits Office to learn about other health plan options available through your group.

## How to receive care

Our facilities include Plan Medical Offices and Plan Hospitals that are listed in either *Your Guidebook to Kaiser Permanente Services, Northern California* or *Your Guidebook to Kaiser Permanente Services, Southern California*. You can receive all the covered Services you routinely need, as well as some specialized care, at these facilities. Unless you have a medical emergency, you should call for advice or for an appointment. We can help you determine whether to schedule an appointment or to come in for same-day medical attention.

### ■ Care in Coachella Valley and western Ventura County

Subscribers residing in Coachella Valley and western Ventura County are required to select a primary care Plan Physician (Affiliated Physician) for themselves and each covered Dependent. In these areas, Plan Providers are referred to as "Affiliated Providers," "Affiliated Physicians," and "Affiliated Specialty Physicians." After enrollment, we will send a letter explaining how to select an Affiliated Physician. If a Subscriber does not select a primary care Affiliated Physician for him or herself and each covered Dependent, we will assign one for each Member in the Family Unit. You may change your primary care Affiliated Physician assignment or selection once a month.

Your primary care Affiliated Physician provides or arranges your care in these areas, including care from other Affiliated Providers, such as Affiliated Specialty Physicians. Except for out-of-Plan emergency care, your primary care Affiliated Physician must prescribe the care or authorize the referral for Services from other Affiliated Providers to be covered.

Covered drugs, supplies, and supplements prescribed by a Plan Physician (including an Affiliated Physician) or any dentist can, upon payment of any applicable Copayments, be obtained from any Plan Pharmacy (including Affiliated Pharmacies).

In addition to the health care Services provided by these Affiliated Providers, you may receive care from Plan Hospitals, Plan Medical Offices, and Plan Physicians outside the Coachella Valley and western Ventura County areas without referral from your primary care Affiliated Physician.

If you need care before we confirm your primary care Affiliated Physician selection, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** for assistance. To learn about our Affiliated Providers, please refer to the *Directory of Kaiser Permanente Affiliated Physicians for Coachella Valley (Greater Palm Springs Area) and western Ventura County*. Please refer to the "Service Area" section in "Section Three, General Information for All Members" for the ZIP codes for these two areas.

If you do not live in one of the Coachella Valley or western Ventura County ZIP codes, you may receive care from an Affiliated Provider without selecting a primary care Affiliated Physician. However, if you wish, you may choose to receive care under the same terms as Members residing in Coachella Valley and western Ventura County, including selecting a primary care Affiliated Physician.

## Getting assistance

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

Most Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, we have a Member Service Call Center staffed with representatives who are available to assist you. Please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.** For your convenience, you can also contact us through the members-only section of our Web site at *www.kaiserpermanente.org*.

Also, Member Service representatives at our Plan Facilities and Member Service Call Center can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace an ID card. These representatives can also help you if you need to file a claim for Emergency Care or Out-of-Area Urgent Care received from non-Plan Providers. In addition, they can help you with any complaints or initiate a grievance for any unresolved issue as discussed in the "Dispute resolution" section.

## Emergency, urgent, and routine care

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

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

## *Your Guidebook*

*Your Guidebook to Kaiser Permanente Services* explains how to use our Services and make appointments, and includes a detailed telephone directory for appointments and advice. It also discusses the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services. *Your Guidebook* is subject to change and is periodically updated. You can get a current copy by calling our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

## 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 seven days a week, 24 hours a day. Our advice nurses are registered nurses (RNs) specially trained to help assess medical problems and provide advice over the phone. Whether you are calling for advice or to make an appointment, you have the option of speaking to an advice nurse. They can often resolve a minor concern over the phone or advise you about what to do next, including making a same-day or next-day urgent care appointment for you if it's appropriate. To reach an advice nurse, please refer to *Your Guidebook* for the telephone numbers.

## Routine care

If you need to make a routine care appointment, please refer to *Your Guidebook* for appointment telephone numbers, or log on to our members-only section of our Web site at *www.kaiserpermanente.org* to make an appointment online. Routine appointments are for health care needs that aren't urgent (for example, routine checkups and school physicals). Try to make your routine care appointments as far in advance as possible.

## Emergency Care

We cover Emergency Care from Plan Providers and non-Plan Providers anywhere in the world. Emergency Care is Medically Necessary ambulance Services and evaluation by appropriate medical personnel to determine if an Emergency Medical Condition exists. If one exists, Emergency Care is also the Medically Necessary care, treatment, and surgery required to stabilize your Emergency Medical Condition (make you Clinically Stable) within the capabilities of the facility. Please refer to the "Benefits" section for information about ambulance coverage.

An Emergency Medical Condition is a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to your health.
- Serious impairment in your bodily functions.
- Serious dysfunction of any bodily organ or part.

An Emergency Medical Condition is also "active labor," which means a labor when there is inadequate time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the Member or unborn child.

If you think you have an Emergency Medical Condition, call 911 or go to the nearest hospital. To better coordinate your Emergency Care, we recommend that you go to a Plan Hospital if it is reasonable to do so considering your condition or symptoms. Please refer to *Your Guidebook* for the location of Plan Hospitals that provide Emergency Care.

### ■ Special note about Post-Stabilization Care

Post-Stabilization Care is the Services you receive after your treating physician determines

that your Emergency Medical Condition is Clinically Stable. We cover Post-Stabilization Care if a Plan Provider provides it or if you obtain authorization from us to receive the care from a non-Plan Provider. To request authorization for Post-Stabilization Care, you must call us 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 and decide whether to authorize your care from the non-Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. Please ask the non-Plan Provider whether we authorized your Post-Stabilization Care.

Please refer to "Call us for non-Plan admissions or Post-Stabilization Care authorization" below for the telephone number to call and additional information about notification requirements.

## 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.

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

## Additional coverage limitations

### Call us for non-Plan admissions or Post-Stabilization Care authorization

You must call us at **1-800-225-8883** (the telephone number to call is also on your ID card) to:

- Request authorization for Post-Stabilization Care before you obtain the care from a non-Plan Provider if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible).
- Notify us that you have been admitted to a non-Plan Hospital. You must notify us within 24 hours of any admission or as soon as reasonably possible. We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you don't notify us as soon as reasonably possible, we will not cover any Services you receive after transfer would have been possible.

**Note:** We know that extraordinary circumstances can delay your ability to call us, for example if you are unconscious or a young child without a parent or guardian. In these cases, you must call us as soon as it is reasonably possible. Please keep in mind that anyone can call us. If you don't call us when it becomes possible for you to call, you will be financially responsible for the cost of the unauthorized Services received after you became Clinically Stable.

### Reimbursement for non-Plan Emergency and Out-of-Area Urgent Care received from non-Plan Providers

Continuing or follow-up treatment is not covered, except as discussed on the previous page. Our reimbursement will be reduced by applicable Copayments, which are the same Copayments required for Services provided by a Plan Provider.

The procedure for obtaining reimbursement for Emergency Care and Out-of-Area Urgent Care received from non-Plan Providers is described in the "Request for payment" section.

# Benefits

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

- A Plan Physician determines that the Services are Medically Necessary to prevent, diagnose, or treat your medical condition. A Service is Medically Necessary only if a Plan Physician determines that it is medically appropriate for you and its omission would adversely affect your health.
- The Services are provided, prescribed, authorized, or directed by a Plan Physician.
- You receive the Services at a Plan Facility or Skilled Nursing Facility within our Service Area, except where specifically noted to the contrary in the following sections about:
  - "Referrals to specialists," in the "How to Obtain Services" section;
  - "Our visiting member program," in the "How to Obtain Services" section;
  - Emergency Care and Out-of Area Urgent Care received from non-Plan Providers in the "Emergency, urgent, and routine care" section;
  - House calls in this section;
  - "Home health care" in this section; and
  - "Hospice care" in this section.

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

Also, please refer to:

- The "Emergency, urgent, and routine care" section for information about how to obtain Emergency Care, urgent, and routine care.
- This "Benefits" and the "Benefit Summary and Copayments" sections for the Copayments you must pay for covered Services.
- *Your Guidebook to Kaiser Permanente Services* for the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services.

## Hospital inpatient care

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

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

- Obstetrical care and delivery (including cesarean section);

  **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge.

- Respiratory therapy; and
- Medical social Services and discharge planning.

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

- "Chemical dependency Services"
- "Dialysis care"
- "Drugs, supplies, and supplements"
- "Durable medical equipment (DME)"
- "Emergency, Post-Stabilization, and urgent care"
- "Hospice care"
- "Imaging, laboratory, and special procedures"
- "Infertility Services"
- "Mental health Services"
- "Ostomy and urological supplies"
- "Physical, occupational, and speech therapy, and multidisciplinary rehabilitation Services"
- "Prosthetic and orthotic devices"
- "Reconstructive surgery"
- "Services associated with Clinical Trials"
- "Skilled Nursing Facility care"
- "Transplant Services"

## Outpatient care

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

- Primary care visits for internal medicine, gynecology (including cervical cancer screening tests and mammograms), family practice, and pediatrics;
- Specialty care visits, including consultation and second opinions with Plan Physicians in departments other than those listed as primary care visits on the previous page.
- Allergy testing;
- Outpatient surgery;
- Respiratory therapy visits;
- Preventive health screenings; and
- Post-transplant care.

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

- Allergy injections.

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

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

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

- "Ambulance Services"

- "Chemical dependency Services"
- "Dialysis care"
- "Drugs, supplies, and supplements"
- "Durable medical equipment (DME)"
- "Emergency, Post-Stabilization, and urgent care"
- "Family planning Services"
- "Health education"
- "Hearing Services"
- "Home health care"
- "Hospice care"
- "Imaging, laboratory, and special procedures"
- "Infertility Services"
- "Mental health Services"
- "Ostomy and urological supplies"
- "Physical, occupational, and speech therapy, and multidisciplinary rehabilitation Services"
- "Prosthetic and orthotic devices"
- "Reconstructive surgery"
- "Services associated with Clinical Trials"
- "Transplant Services"
- "Vision Services"

## Ambulance Services

We cover the emergency Services of a licensed ambulance at **no charge.** We cover emergency ambulance Services that are not ordered by us if you reasonably believe all of the following:

- You are experiencing 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, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part; and
- Your condition requires ambulance transportation.

We also cover nonemergency ambulance Services for transportation if, in the judgment of a Plan Physician, your condition requires the use of medical Services that only a licensed ambulance can provide and the use of other means of transportation would endanger your health.

### ■ Ambulance Services exclusions

Transportation by car, taxi, bus, gurney van, wheelchair van, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider, is not covered.

## Chemical dependency Services

#### Inpatient detoxification

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

#### Outpatient

We cover the following Services for treatment of chemical dependency:

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

  **$10 per individual therapy visit**

  **$5 per group therapy visit**

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

**Transitional residency recovery Services**

We cover up to 60 days per calendar year of care in a nonmedical transitional residency recovery setting approved in writing by the Medical Group at **$100 per admission;** no more than 120 days of covered care is provided in any five-consecutive-calendar-year period.

These settings provide counseling and support Services in a structured environment.

### ■ Chemical dependency Services exclusions

- Services in a specialized facility for alcoholism, drug abuse, or drug addiction, except as described above.
- We will discontinue counseling or treatment if you are disruptive or physically abusive.

## 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;
- The facility is certified by Medicare; and
- A Plan Physician provides a written referral for care at the facility.

**Inpatient care: $250 per admission**

**Outpatient care: $10 per visit**

**Dialysis treatment: $10 per visit**

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

## Drugs, supplies, and supplements

We cover drugs, supplies, and supplements specified below when prescribed by a Plan Physician (except as otherwise described under "Outpatient drugs, supplies, and supplements") and in accord with our drug formulary guidelines. Also, you must obtain covered drugs, supplies, and supplements from a Plan Pharmacy or another pharmacy that we designate. It may be possible for you to receive refills by mail; ask for details at our pharmacy.

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

### ■ Administered drugs and self-administered IV drugs

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

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

**Self-administered IV drugs, supplies, and supplements.** We cover certain drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as IV or intraspinal-infusion) at **no charge.** We also

cover the supplies and equipment required for their administration. Injectable drugs, insulin, and drugs for the treatment of infertility are not covered under this paragraph.

## ■ Diabetes urine-testing supplies and certain insulin-administration devices

We cover the following diabetes urine-testing supplies:

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

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

We cover the following insulin-administration devices:

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

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

## ■ Outpatient drugs, supplies, and supplements

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

We cover at **$10 generic/$20 brand name per prescription for up to a 100-day supply*:**

- Drugs for which a prescription is required by law. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary.
- Smoking-cessation drugs are covered if you participate in a Plan-approved behavior intervention program.
- Diaphragms, cervical caps, and oral contraceptives.
- Disposable needles and syringes needed for injecting covered drugs.

* Prescription drug quantities that exceed a 100-day supply will be provided at Charges, not the Copayment.

**Note:** If the Copayment is greater than Charges for a prescription, the Member pays the lower amount. The Charges is the amount a Member would pay for the prescription if the Member's benefit plan did not cover prescription drugs.

We cover the following at **50 percent of Charges:**

- Drugs for diagnosis and treatment of infertility.

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

- Episodic drugs, as prescribed by a Plan Physician, will be provided up to a maximum of **27 doses in any 100-day period at 50 percent of Charges. Additional prescribed doses that exceed the dose maximum during the same 100 days will be dispensed at Charges.**
- Maintenance (nonepisodic) drugs, as prescribed by a Plan Physician, that require doses at regulated intervals will be provided at **50 percent of Charges for up to a 100-day supply. Quantities in excess of a 100-day supply will be provided at Charges.**

## ■ Special note 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. Our drug formulary guidelines allow you to obtain prescription drugs that are not listed on the drug formulary for your condition if a Plan Physician determines that they are Medically Necessary. Also, our formulary guidelines may require you to participate in a Plan-approved behavioral intervention program for specific conditions, and you may be required to pay for the program. If you would like information about whether a particular drug is included in our drug formulary, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

**Note:** If a drug for which a prescription is required by law is no longer covered and we had been covering and providing it to you for a use approved by the FDA, we will continue to provide the drug upon payment of a 50 percent Copayment if a Plan Physician continues to prescribe the drug for the same condition.

### ■ Drugs, supplies, and supplements exclusions

- Any drugs, supplies, and supplements needed in connection with a Service that is not covered under this *DF/EOC,* unless they are required to treat a complication that arises after a noncovered Service.
- Compounded products, unless the product is listed on the drug formulary, or one of the ingredients requires a prescription by law.
- Drugs to shorten the duration of the common cold.
- Any requested packaging (such as dose packaging), other than the dispensing pharmacy's standard packaging.

## Durable medical equipment (DME)

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

We cover durable medical equipment as prescribed by a Plan Physician for use in your home (or an institution used as your home). We also cover equipment, including oxygen-dispensing equipment and oxygen used during a covered stay in a Plan Hospital or a Skilled Nursing Facility, if a Skilled Nursing Facility ordinarily furnishes the equipment.

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 for the equipment when we are no longer covering it.

**Note:** Diabetes urine-testing supplies and other insulin-administration devices are not covered under this section (refer to "Drugs, supplies, and supplements").

### ■ Durable medical equipment exclusions

We do not cover:

- Comfort, convenience, or luxury equipment or features;
- Exercise or hygiene equipment;

- Dental appliances;
- Nonmedical items such as sauna baths, whirlpools, or elevators;
- Modifications to your home or car;
- Electronic monitors of the heart or lungs, except infant apnea monitors;
- More than one piece of equipment to serve the same purpose; or
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies, such as blood glucose monitor test strips and lancets).

## Emergency, Post-Stabilization, and urgent care

### ■ Emergency Care

We cover Emergency Care from Plan Providers and non-Plan Providers anywhere in the world. Emergency Care is Medically Necessary ambulance Services and evaluation by appropriate medical personnel to determine if an Emergency Medical Condition exists. If one exists, Emergency Care is also the Medically Necessary care, treatment, and surgery required to stabilize your Emergency Medical Condition (make you Clinically Stable) within the capabilities of the facility.

**Note:** Please refer to "Ambulance Services" in this section for information about ambulance coverage.

An Emergency Medical Condition is a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain), such that you could reasonably expect the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to your health.
- Serious impairment in your bodily functions.
- Serious dysfunction of any bodily organ or part.

An Emergency Medical Condition is also "active labor," which means a labor when there is inadequate time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the Member or unborn child.

If you think you have an Emergency Medical Condition, call 911 or go to the nearest hospital. To better coordinate your Emergency Care, we recommend that you go to a Plan Hospital if it is reasonable to do so considering your condition or symptoms. Please refer to *Your Guidebook* for the location of Plan Hospitals that provide Emergency Care.

**Emergency Care: $50 per visit** (charge waived if admitted to hospital)

### ■ Post-Stabilization Care

Post-Stabilization Care is the Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable. We cover Post-Stabilization Care if a Plan Provider provides it or if you obtain authorization from us to receive the care from a non-Plan Provider.

To request authorization for Post-Stabilization Care, you must call us 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 and decide whether to authorize your care from the non-Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. Please ask the non-Plan Provider whether we authorized your Post-Stabilization Care.

Please refer to "Call us for non-Plan admissions or Post-Stabilization Care authorization" below for the telephone number to call and additional information about notification requirements.

## ■ 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.

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

**Out-of-Area Urgent Care at non-Plan Facilities:**

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

**$50 per visit, if seen in an emergency room**

## ■ Additional coverage limitations

**Call us for non-Plan admissions or Post-Stabilization Care authorization.** You must call us at **1-800-225-8883** (the telephone number to call is also on your ID card) to:

- Request authorization for Post-Stabilization Care before you obtain the care from a non-Plan Provider if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible).
- Notify us that you have been admitted to a non-Plan Hospital. You must notify us within 24 hours of any admission or as soon as reasonably possible. We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you don't notify us as soon as reasonably possible, we will not cover any Services you receive after transfer would have been possible.

**Note:** We know that extraordinary circumstances can delay your ability to call us, for example if you are unconscious or a young child without a parent or guardian. In these cases, you must call us as soon as it is reasonably possible. Please keep in mind that anyone can call us. If you don't call us when it becomes possible for you to call, you will be financially responsible for the cost of the unauthorized Services received after you became Clinically Stable.

## ■ Reimbursement for non-Plan Emergency and Out-of-Area Urgent Care received from non-Plan Providers

Continuing or follow-up treatment is not covered, except as discussed above. Our reimbursement will be reduced by applicable Copayments, which are the same Copayments required for Services provided by a Plan Provider.

The procedure for obtaining reimbursement for Emergency Care and Out-of-Area Urgent Care received from non-Plan Providers is described in the "Request for payment" section.

## Family planning Services

We cover:

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

**Inpatient Services: $250 per hospital inpatient admission**

**Outpatient visits: $10 per visit**

**Note:**

- Diagnostic procedures are not covered under this section. See "Imaging, laboratory, and special procedures" in this "Benefits" section.
- Contraceptive drugs and devices are not covered under this section. See "Drugs, supplies, and supplements" in this "Benefits" section.

### ■ Family planning Services exclusions

We do not cover Services to reverse voluntary, surgically induced infertility.

## Health education

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

**Individual office visit: $10 per visit**

**All other covered Services: No charge**

## Hearing Services

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

**Hearing aid(s).** We cover the following:

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

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

### ■ Hearing Services exclusions

We do not cover:

- Replacement parts and batteries;
- Replacement of lost or broken hearing aids;
- Repair of hearing aids after the warranty period;
- Internally implanted hearing aids;
- Comfort, convenience, or luxury equipment or features; and
- Hearing aids prescribed or ordered before the effective date or after the termination date of your coverage.

## Home health care

We cover the following home health care Services at **no charge:**

- Only within our Service Area;

- Only if you are substantially confined to your home; and
- Only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home.

Home health care Services are Medically Necessary health Services that can be safely and effectively provided in your home by health care personnel, prescribed by a Plan Physician, and directed by our Home Health Committee, which is comprised of Plan Physicians and other health care professionals.

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

- "Drugs, supplies, and supplements"
- "Durable medical equipment (DME)"
- "Ostomy and urological supplies"
- "Physical, occupational, and speech therapy, and multidisciplinary rehabilitation Services"
- "Prosthetic and orthotic devices"

### ■ Home health care exclusions

Home health Services do not include:

- Custodial care (see definition under "Exclusions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section), and homemaker Services;
- Care that the Home Health Committee determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, and we provide or offer to provide that care in one of these facilities.

## Hospice care

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

We cover the Services listed below only if all of the following requirements are met:

- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less;
- The Services are provided inside our Service Area by a licensed hospice agency approved by the Medical Group; and
- The Services are necessary for the palliation and management of your terminal illness and related conditions.

If all of the above requirements are met, we cover the following hospice Services at **no charge,** which are available on a 24-hour basis to the extent necessary for your hospice care:

- Plan Physician Services.
- Skilled nursing care including assessment, evaluation and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers.
- Physical, occupational, or speech therapy for purposes of symptom control, or to enable you to maintain activities of daily living.
- Respiratory therapy.
- Medical social Services.
- Home health aide and homemaker Services.

- Palliative drugs prescribed for pain control and symptom management of the terminal illness up to a 100-day supply in accord with our drug formulary guidelines.

  You must obtain these drugs from Plan Pharmacies or other pharmacies that we designate. Certain drugs are limited to a maximum 30-day supply in any 30-day period; please call our Member Service Call Center for the current list of these drugs.
- Durable medical equipment.
- Respite care, which is occasional short-term inpatient care limited to no more than five consecutive days at a time, when necessary to relieve your caregivers.
- Counseling and bereavement Services.
- Dietary counseling.
- The following care during periods of crisis when you need continuous care to achieve palliation or management of acute medical symptoms: nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home and short-term inpatient care required at a level that cannot be provided at home.

## Imaging, laboratory, and special procedures

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

- Diagnostic and therapeutic imaging;
- Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available;
- Special procedures such as electrocardiograms and electroencephalograms; and
- Ultraviolet light treatment.

We cover the following Services at **50 percent of Charges:**

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

## Infertility Services

We cover the following Services at **50 percent of Charges:**

- 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:**

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

### ■ Infertility Services exclusions

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

## Mental health Services

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

- Serious emotional disturbances of a child as defined in Section 1374.72(e) of the California Health and Safety Code.

- 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.

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

### Outpatient mental health Services

We cover, at **$10 per visit:**

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

### Inpatient psychiatric care

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

### Hospital alternative Services

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

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

## Ostomy and urological supplies

Within our Service Area, we cover ostomy and urological supplies prescribed in accord with our durable medical equipment (DME) formulary guidelines, during a covered stay in a Plan Hospital or Skilled Nursing Facility, in Plan Medical Offices and Plan Hospital Emergency Departments, and for home use at **no charge.** Coverage is limited to the standard item of equipment that adequately meets your medical needs.

### ■ Ostomy and urological supplies exclusions

We do not cover comfort, convenience, or luxury equipment or features.

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

### ■ Physical, occupational, and speech therapy

If, in the judgment of a Plan Physician, significant improvement is achievable, we will cover prescribed courses of physical, occupational, and speech therapy in a Plan Facility or Skilled Nursing Facility or as part of home health care.

**Inpatient Services: No charge**

**Outpatient visits: $10 per visit**

### ■ Limitations

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

## ■ Multidisciplinary rehabilitation Services

If a Plan Physician determines that significant improvement in function is achievable, we will cover treatment in a prescribed, organized, multidisciplinary rehabilitation program in a Plan Facility or Skilled Nursing Facility.

**Inpatient Services: No charge**

**Outpatient visits: $10 per visit**

## Prosthetic and orthotic devices

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

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

## ■ Internally implanted devices

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

## ■ External devices

We cover the following external 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 (including electronic voice-producing devices for Medicare Members only);
- Prostheses needed after a covered mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres every 12 months;
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan podiatrist, physiatrist, or orthopedist;
- Compression burn garments and lymphedema wraps and garments; and
- Other covered prosthetic and orthotic devices:
  - Prosthetic devices required to replace all or part of an organ or extremity, or the function of either;
  - Rigid and semi-rigid orthotic devices required to support or correct a defective body part; and
  - Special footwear for foot disfigurement due to disease, injury, or developmental disability.

## ■ Prosthetic and orthotic devices exclusions

We do not cover:

- Eyeglasses and contact lenses;
- Hearing aids under this benefit (please see “Hearing Services” in this “Benefits” section);
- Dental appliances;
- Except as indicated above, nonrigid supplies such as elastic stockings and wigs;
- Comfort, convenience, or luxury equipment or features;

- Electronic voice-producing machines; and
- Shoes or arch supports, even if custom-made, unless as indicated above.

## Reconstructive surgery

We cover reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Plan Physician determines that it is necessary to improve function or create a normal appearance, to the extent possible.

### ■ Mastectomies

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

**Inpatient Services: $250 per admission**

**Outpatient visits: $10 per visit**

### ■ 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; and
- Prosthetic and orthotic devices are covered only as described under "Prosthetic and orthotic devices" in this "Benefits" section.

## Services associated with Clinical Trials

We cover Services associated with cancer Clinical Trials if all of the following requirements are met:

- You are diagnosed with cancer;
- You are accepted into a phase I, II, III, or IV Clinical Trial for cancer;
- Your treating Plan Physician recommends participation in the Clinical Trial after determining that it has a meaningful potential to benefit you (non-Plan Provider Services are covered in accord with "Referrals to specialists" under the "How to Obtain Services" in this section);
- The Services would be covered under this *DF/EOC* if they were not provided in connection with a Clinical Trial;
- The Clinical Trial has a therapeutic intent, and its endpoints are not defined exclusively to test toxicity; and
- The Clinical Trial involves a drug that is exempt under federal regulations from a new drug application, or the Clinical Trial is approved by: one of the National Institutes of Health, the federal Food and Drug Administration (in the form of an investigational new drug application), the U.S. Department of Defense, or the U.S. Department of Veterans Administration.

### ■ Services associated with Clinical Trials exclusions

- Services that are provided solely to satisfy data collection and analysis needs and are not used in your clinical management;
- Services that are customarily provided by the research sponsors free of charge to enrollees in the Clinical Trial; and
- Services associated with the provision of drugs or devices that have not been approved by the federal Food and Drug Administration.

## Skilled Nursing Facility care

Within our Service Area, we cover up to 100 days per calendar year of Medically Necessary skilled inpatient Services prescribed by a Plan Physician in a licensed Skilled Nursing Facility. The skilled inpatient Services must be customarily provided by Skilled Nursing Facilities and above the level of custodial or intermediate care. A prior three-day stay in an acute-care hospital is not required.

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

- Physician and nursing Services;
- Room and board;
- Medical social Services;
- Blood, blood products, blood transfusions, and their administration;
- Equipment described under "Durable medical equipment (DME)," and oxygen;
- Medical supplies;
- Respiratory therapy;
- Drugs covered under "Drugs, supplies, and supplements" in this "Benefits" section;
- Procedures covered under "Imaging, laboratory, and special procedures" in this "Benefits" section; and
- Services covered under "Physical, occupational, and speech therapy, and multidisciplinary rehabilitation Services" in this "Benefits" section.

## Transplant Services

We cover transplants of organs, tissue, or bone marrow, when a Plan Physician provides a written referral for care to a transplant facility as described in "Referrals to specialists," in this "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; and
- In accord with our criteria for donor Services, we provide certain donation-related Services for a donor, or an individual identified by the Medical Group as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. Our criteria for donor Services are available by calling our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

  **Inpatient Services: $250 per admission**

  **Outpatient visits: $10 per visit**

### ■ Transplant Services exclusions

We do not cover:

- Services related to nonhuman or artificial organs and their implantation.

## Vision Services

We cover:

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

### ■ Vision Services exclusions

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

### ■ Eyeglasses and contact lenses following cataract surgery

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

# Exclusions, Limitations, Coordination of Benefits, and Reductions

## Exclusions

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

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

  1. Required for obtaining or maintaining employment or participation in employee programs, or
  2. Required for insurance or licensing, or
  3. On court order or required for parole or probation.

  This exclusion does not apply if a Plan Physician determines that the Services and supplies are Medically Necessary.

- **Chiropractic Services.**

- **Conception by artificial means.** All Services (other than artificial insemination described under "Infertility Services") related to conception by artificial means, such as but not limited to 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.** Plastic surgery or other cosmetic Services that are intended primarily to improve your appearance, except for Services covered under "Reconstructive surgery" in the "Benefits" section.

- **Custodial care.** Custodial care means:

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

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

- **Dental care.** Dental care and dental X-rays, such as dental Services following accidental injury to teeth, dental appliances, dental implants, orthodontia, and dental Services resulting from medical treatment (such as surgery on the jawbone and radiation treatment). This exclusion does not apply to evaluation, extraction, dental X-rays, or fluoride treatment, if a Plan Physician refers you to a dentist (as described under "Referrals to specialists") to prepare your jaw for radiation treatment of cancer.

- **Experimental or investigational Services.** A Service is experimental or investigational if we, in consultation with the Medical Group, determine that:

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

This exclusion does not apply to Services covered under "Services associated with Clinical Trials" in the "Benefits" section.

Please refer to the "Dispute resolution" section for information about independent medical review related to denied requests for experimental or investigational Services.

- **Hair loss or growth treatment.** Services for promotion, prevention, or other treatment of hair loss or hair growth.
- **Intermediate care.** Care in a licensed, intermediate care facility. This exclusion does not apply to Services covered under "Hospice care" in the "Benefits" section.
- **Routine foot care Services.** Routine foot care Services that are not Medically Necessary.
- **Services not available in our Service Area.** Services not generally and customarily available in our Service Area except when it is generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.
- **Sexual reassignment surgery.**
- **Surrogacy.** Services for anyone in connection with a surrogacy arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. Also, Services related to conception by artificial means related to a surrogacy arrangement. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. Please refer to "Surrogacy arrangements" in the "Reductions" section for information about your obligations to us in connection with a surrogacy arrangement, including your obligation to reimburse us for any Services we cover.
- **Travel and lodging expenses.** Travel and lodging expenses for any person, including a Member. However, in some situations, if we refer you to a non-Plan Provider as described under "Referrals to specialists" in the "How to Obtain Services" section, we may preauthorize certain expenses in accord with our travel and lodging policy and so notify you. An example of a situation where we would authorize such expenses is if we were to refer a Member outside of California to receive covered care that is not available from any provider within the state.

## Limitations

- We will use our best efforts 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 of a Plan Facility, complete or partial destruction of facilities, and labor disputes not involving Health Plan, Kaiser Foundation Hospitals, or the Medical Group). However, Health Plan, Kaiser Foundation Hospitals, the Medical Group, and the Medical Group Physicians will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan,

Kaiser Foundation Hospitals, or the Medical Group, we may postpone routine or elective care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences in the judgment of a Plan Physician.

## Coordination of benefits (COB) for the Traditional Plan

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

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

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

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

## Reductions

- **Employer responsibility.** For any Services that the law requires an employer to provide, we will not pay the employer, and if 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 if we cover any such Services we may recover the value of the Services from the government agency.
- **Medicare benefits.** Your benefits are reduced by any benefits to which you are entitled under Medicare except for Members whose Medicare benefits are secondary by law.
- **Surrogacy arrangements.** You must pay us the Charges for covered Services you receive related to conception, pregnancy, or delivery in connection with a surrogacy arrangement ("Surrogacy Health Services"). Your obligation to pay us for Surrogacy Health Services is limited to the compensation you are entitled to receive under the surrogacy arrangement. A surrogacy arrangement is one in which you agree to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or your chosen payee under the surrogacy arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments. Those payments shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within 30 days after entering into a surrogacy arrangement, you must send written notice of the arrangement, including the names and addresses of the other parties to the arrangement, and a copy of any contracts or other documents explaining the arrangement, to the following addresses:

***Northern California Members:***

Kaiser Permanente
Special Recovery Unit
COB/TPL
P.O. Box 2073
Oakland, CA 94604-9877
Attention: Third Party Liability Supervisor

***Southern California Members:***

Kaiser Permanente
Special Recovery Unit
Parsons East, 2nd Floor
P.O. Box 7017
Pasadena, CA 91109-9977
Attention: Third Party Liability Supervisor

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy arrangements" section and to satisfy those rights. You must not take any action prejudicial to our rights.

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

- **Veterans Administration.** For any Services for conditions arising from military service that the law requires the Veterans Administration to provide, we will not pay the Veterans Administration, and if we cover any such Services we may recover the value of the Services from the Veterans Administration.
- **Workers' compensation or employer's liability benefits.** You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as a "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any such Services from the following sources:

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

# Request for Payment or Services

## Request for payment

### ■ Non-Plan Emergency or Out-of-Area Urgent Care

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

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

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

***Southern California Members:***
Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 7102
Pasadena, CA 91109-9880
**1-800-390-3510**

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

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

## Other Services

To request payment for Services (except Emergency Care or Out-of-Area Urgent Care from non-Plan Providers) that you believe should be covered, you must submit a written request to your local Member Services Department. Please attach any bills and receipts, if you have paid any bills.

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

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

## Requests for Services

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

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

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

**Expedited decision.** You or your physician may make an oral or written request that we expedite our decision about your request. We will inform you of our decision within 72 hours (orally or in writing) if we find, or your physician states, that waiting 15 days for our "standard decision":

- Could seriously jeopardize your life, health, or ability to regain maximum function.
- Would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting.

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

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

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

  Kaiser Foundation Health Plan, Inc.
  Advocacy Program
  P.O. Box 12983
  Oakland, CA 94604-2983
  Attention: Expedited Review
- Fax your written request to **1-888-987-2252.**
- Deliver your request in person to your local Member Services Department.

## Dispute resolution

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

## Grievances

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

You can file a grievance for any issue. Your grievance must explain your issue, (such as the reasons why you believe a decision was in error or why you are dissatisfied about the Services you received.) Grievances may be submitted orally or in writing and they must be submitted to:

- The following locations for claims described under "Non-Plan Emergency or Out-of-Area Urgent Care" in the "Request for payment" section:

***Northern California Members:***

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

***Southern California Members:***

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

- A Member Service representative for all other issues.

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

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

### ■ Expedited grievance

You or your physician may make an oral or written request that we expedite our decision about your grievance. We will inform you of our decision within 72 hours (orally or in writing) if we find, or your physician states, that waiting 30 days for our decision:

- Could seriously jeopardize your life, health, or ability to regain maximum function; or
- Would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting.

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

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

- Call toll free **1-888-987-7247.**

- Send your written request to:

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

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

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

## Providing supporting documents for your request

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

## Who may file

The following persons may file a grievance:

- You may file for yourself. If you want someone to file for you, provide us in writing your name, your Medical Record Number, and a statement that appoints an individual as your authorized representative. An example of a statement is: "I [your name] appoint [name of representative] to act as my representative in filing a grievance about Health Plan's [denial] [discontinuation] of Services." You must sign and date the statement. Your representative must also sign and date this statement unless he or she is an attorney. Include this signed statement with your grievance. (Authorization forms are also available from any Member Services Department.)
- In most cases, you may file for your Dependent child. In some cases, your child will have to appoint you as his or her authorized representative.
- A court-appointed guardian or an agent under a health care proxy to the extent provided under state law.

## DMHC complaints

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. The department has a toll-free telephone number **1-888-HMO-2219** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone number **1-877-688-9891 (TDD)** to contact the department. The department's Internet Web site **(http://www.hmohelp.ca.gov)** has complaint forms and instructions online.
If you have a grievance against your health plan, you should first telephone your plan at **1-800-464-4000** and use the plan's grievance process before contacting the department.
If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for

more than 30 days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

## 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 your issue has been denied or it is unresolved after 30 days (or three days if the request meets expedited review criteria), and one of the following criteria applies:

- Your request for a Service, that would otherwise be eligible for coverage, has been denied, modified, or delayed based in whole or in part on a decision that the Service is not Medically Necessary; or
- The Service you requested is for the treatment of a life-threatening or seriously debilitating condition and has been denied on the basis that it is experimental or investigational, and your treating physician certifies that you have a condition for which the standard therapies have not been effective for this condition or would not be medically appropriate for you, or we do not cover a more beneficial standard therapy than the one proposed by you or your physician. If you request IMR for this reason, the DMHC requires that you submit the following information to them:
  - A written statement from your treating physician that states you meet these criteria and that standard therapies have not been effective in treating your condition, or that describes the clinical reasons that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we cover than the therapy being requested.
  - If your treating physician is a Plan Physician, he or she must also include a statement verifying that the requested therapy is likely to be more beneficial to you than any available standard therapies. If your treating physician is not a Plan Physician, please contact our Member Service Call Center at **1-800-464-4000** or the DMHC regarding non-Plan Physician supporting documentation requirements for the IMR process.

If the DMHC determines that your case is eligible for independent medical review, 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.

## Binding arbitration

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

1. The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *DF/EOC* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc., (Health Plan), including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, Services, irrespective of the legal theories upon which the claim is asserted;

2. The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties; and
3. The claim is *not* within the jurisdiction of the Small Claims Court.

As referred to in this "Binding arbitration" section,

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

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.

**Arbitration Advisory Committee and Independent Administrator.** Health Plan appointed an Arbitration Advisory Committee to assist in the selection of an Independent Administrator to administer arbitrations under this "Binding arbitration" section, and to provide consultation to the Independent Administrator in administering these arbitrations. Upon the recommendation of the Arbitration Advisory Committee, Health Plan selected an Independent Administrator to perform these administrative services.

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

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

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

***Southern California Members***
Kaiser Foundation Health Plan, Inc.
Legal Department
393 E. Walnut St.
Pasadena, CA 91188

Service on that Respondent shall be deemed completed when received.

All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

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

Any Claimant who claims extreme hardship may request that the independent administrator waive the filing fee and the Neutral Arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling the Kaiser Permanente Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

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

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

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

**Payment of Arbitrator fees and expenses.** Health Plan will pay the fees and expenses of the Neutral Arbitrator under certain conditions as set forth in the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* (Rules of Procedure). In all other arbitrations, the fees and expenses of the Neutral Arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select Party Arbitrators, Claimants shall be responsible for paying the fees and expenses of their Party Arbitrator and Respondents shall be responsible for paying the fees and expenses of their Party Arbitrator.

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

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

**General provisions.** A claim shall be waived and forever barred if:

1. On the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondents served by the applicable statute of limitations; or
2. Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence; or
3. The arbitration hearing is not commenced within five years after the earlier of (i) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (ii) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim.

A claim may be dismissed on other grounds by the Neutral Arbitrator based on a showing of good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the Neutral Arbitrator may proceed to determine the controversy in the party's absence.

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

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

# Termination of Membership

The University is required to inform the Subscriber of the date your coverage terminates. If your membership terminates, all rights to benefits end at 12 a.m. on the termination date (for example, if your termination date is January 1, 2003, your last moment of coverage was at 11:59 p.m. on December 31, 2002).

In addition, a Dependent's membership ends at the same time the Subscriber's membership ends. You will be billed as a non-Member for any health care Services you receive after your membership terminates.

If the University terminates its *Group Agreement* for any reason, or if Health Plan terminates the *Group Agreement* because of nonpayment of monthly Dues, the coverage of all Members (except disabled Members eligible for coverage as described below) enrolled through the group will end on the date the *Group Agreement* terminates, and the Members have no right to convert to Individual Plan membership. When your membership terminates under this section, Health Plan and Plan Providers have no further liability or responsibility under this *DF/EOC,* except as provided under "Termination of *Group Agreement*" and "Payments after termination" in this "Termination of Membership" section.

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

## Termination of *Group Agreement*

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

### Coverage for totally disabled persons

If you became totally disabled after December 31, 1977, while you were a Member under the University's *Group Agreement* with us, and while the Subscriber was employed by the University, and the University's *Group Agreement* with us terminates, coverage for your disabling condition will continue until any one of the following events occurs:

- 12 months have elapsed, or
- You are no longer disabled, or
- The University's *Group Agreement* with us is replaced by another group health plan without limitation as to the disabling condition.

Your coverage will be subject to the terms of this *DF/EOC,* including Copayments.

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 makes the child unable to substantially engage in any of the normal activities of children in good health of like age.

## Termination due to loss of eligibility

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

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

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

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

   **Child:** Your child loses eligibility as a Dependent:

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

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

Dependents who lose eligibility as your Dependents may continue Kaiser Permanente membership with no break in coverage either through COBRA (please see the "Continuation of group coverage under federal or state law" section for details), or by converting to their own Individual Plan membership. Each Dependent will have to complete an application and submit it to a local Health

Plan Member Service Office. Individual Plan applications may be submitted within 31 days after he or she no longer qualifies as a Dependent under this *DF/EOC*. Mail applications to:

Kaiser Foundation Health Plan, Inc.
P.O. Box 23059
San Diego, CA 92193-9922

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

## Termination for cause

If you commit one of the following acts, we may terminate your membership by sending written notice to the Subscriber:

- You knowingly:
  1. Misrepresent membership status;
  2. Present an invalid prescription or physician order;
  3. Misuse (or let someone else misuse) a Member ID card; or
  4. Commit any other type of fraud in connection with your membership.
- You knowingly furnish incorrect or incomplete information to us or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits.

The University requires that a Dependent who commits fraud or deception will be permanently disenrolled while any other Dependent and the Subscriber will be disenrolled for 18 months. If a Subscriber commits fraud or deception, the Subscriber and any Dependents will be disenrolled for 18 months.

## Termination for nonpayment

### ■ Nonpayment of Dues

You are entitled to health care coverage only for the period for which we receive the appropriate Dues from your group. If your group fails to pay us the appropriate Dues for your Family Unit, we will terminate the memberships of everyone in the Family Unit.

**Partial payment of Dues for a Family Unit.** If your group makes a partial Dues payment specifically for your Family Unit and does not pay us the entire Dues required for your Family Unit, we will terminate the memberships of everyone in the Family Unit effective the last day of the month at 11:59 p.m. in which our determination is made.

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

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

If you do not comply with all of these requirements for any reason, even if you are unable to enroll in Kaiser Permanente Senior Advantage because you do not meet the plan's

eligibility requirements, the plan is not available through your group, or Senior Advantage is closed to enrollment, we will increase your group's Dues to compensate for the lack of Medicare payment and transfer your membership to our non-Medicare plan if you are not already so enrolled. However, if your group does not pay us the entire Dues required for your Family Unit, we will terminate the memberships of everyone in the Family Unit in accord with this section.

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

## ■ Nonpayment of any other Charges

We may terminate the memberships of the Subscriber and all Dependents if any one of them fails to pay any amounts he or she owes to Health Plan, Kaiser Foundation Hospitals, or the Medical Group, or fails to pay Copayments to any Plan Provider. We will send written notice of the termination to the Subscriber at least 15 days before the termination date. After the effective date of termination, you and your Dependents may become Members in the future only by paying all amounts you owe us, completing an enrollment application, and enrolling when next eligible as described in the "Who is eligible" and "Enrollment" sections.

If we terminate your membership or the membership of anyone in your Family Unit for cause or for nonpayment, the individuals in your Family Unit will not be eligible to convert to Individual Plan membership or to enroll in any other Kaiser Permanente coverage or in any Plan that offers Services through Kaiser Permanente.

## Payments after termination

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

- Refund any amounts we owe the University for Dues paid for the period after the termination date, and
- Pay you any amounts we have determined that we owe you for claims for Emergency Care during your membership. We will deduct any amounts you owe Health Plan, Kaiser Foundation Hospitals, or the Medical Group from any amount we owe you.

## 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 that particular product upon 90 days prior written notice to the Subscriber. If we discontinue offering all products to groups in a small or large group market, as applicable, we may terminate the *Agreement* upon 180 days prior written notice to the Subscriber.

## 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" under the "Dispute resolution" section).

## Continuation of group coverage under federal or state law (COBRA)

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

You must submit a COBRA election form to your group within the COBRA election period. Please ask your group's benefits administrator for the details about COBRA continuation coverage, such as how to enroll and how much you must pay.

If you choose not to apply for COBRA continuation coverage through your group, you may be able to convert to a nongroup Plan as described in "Conversion of membership" on the next page. If you do enroll in COBRA, when you lose your COBRA eligibility, you may be able to continue coverage under state law as described in "State continuation coverage after COBRA coverage." Also, you may be able to convert to a nongroup Plan as described in "Conversion of membership" on the next page.

## Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this *DF/EOC* for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. Members are not ineligible for USERRA continuation coverage solely because they live in the service area of a Region outside of California. You must submit a USERRA election form to your group within 60 days after your call to active duty. Please contact your group if you want to know how to elect USERRA coverage and how much you must pay your group.

### ■ State continuation coverage after COBRA coverage

If you lose eligibility for COBRA coverage because you exhaust the length of time allowed for COBRA coverage, you may be eligible to continue your group coverage under state law (state continuation coverage) if required by Section 1373.621 of the California Health and Safety Code. To continue your group coverage under state law, you must call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** to request enrollment within 30 days before the date COBRA continuation coverage is scheduled to end and pay applicable Dues to us. In addition, you must meet one of the following requirements:

- You are a Subscriber who was 60 years of age or older and were employed by your group for at least five (5) years before the date employment with your group terminated; or
- You are the Spouse of a Subscriber who dies, divorces, legally separates, or becomes entitled to Medicare; or
- You are a former Spouse of a Subscriber.

### ■ Termination of state continuation coverage

Coverage continues only upon payment of applicable monthly Dues to us at the time we specify, and terminates on the earliest of:

- The date your group's *Agreement* with us terminates;

- 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 coverage was scheduled to end, if you are a Subscriber's Spouse or former Spouse; or
- When you fail to make payments to us when due.

If you do not elect state continuation coverage, you may be able to convert to a nongroup Plan as described in "Conversion of membership" below.

## Conversion of membership

You may be eligible to convert to a nongroup plan (Individual Plan) if you no longer meet the eligibility requirements described in the "Who is eligible" section, or if you enroll in COBRA or USERRA continuation coverage and then lose eligibility for that coverage. However, you may not convert to this nongroup plan if any of the following is true:

- You continue to be eligible for coverage through your group;
- Your membership ends because your *Agreement* with your group terminates;
- We terminated your membership under "Termination for cause" or "Nonpayment of any other Charges;"
- You live in the service area of a Region outside of California, except that the Subscriber's or the Subscriber's Spouse's otherwise eligible children are not ineligible to be covered Dependents solely because they live in a non-California Region if:
  - They are attending an accredited college or vocational school; or
  - The Subscriber or Subscriber's Spouse is required to cover them pursuant to a Qualified Medical Child Support Order.

You must apply to convert your membership within 31 days after your group coverage ends. During this period, no medical review is required, and your individual coverage begins when your group coverage ends. You will have to pay Dues, and the benefits and Copayments under the new coverage may differ from those under this *DF/EOC*. For information about converting your membership or about Individual Plans, call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

## Certificates of Creditable Coverage

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

SECTION TWO

# Kaiser Permanente Senior Advantage Plan

■

*Kaiser Permanente*

*Combined Disclosure Form and*

*Evidence of Coverage*

*for the*

*University of California*

*Effective January 1, 2003*



**Member Service Call Center**
**1-800-464-4000**
**7 a.m. to 7 p.m., seven days a week**

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

**www.kaiserpermanente.org**

SECTION TWO

# Kaiser Permanente Senior Advantage Plan

## Table of Contents

# Senior Advantage Plan Summary of Changes Effective January 1, 2003

Unless otherwise indicated, effective January 1, 2003, the following is a summary of the most important changes and clarifications that will apply to your Senior Advantage Plan coverage for the year 2003:

### Hospital inpatient Copayment

There will be a $250 hospital inpatient admission Copayment. Previously, the hospital inpatient admission Copayment was $200.

### Allergy testing visit Copayment

The allergy testing visit Copayment will equal the office visit Copayment of $10. It was previously $3.

**Note:** The allergy injection visit Copayment will remain at $3.

### Drugs, supplies, and supplements

- Smoking-cessation drugs will no longer be limited to one course of treatment per year. They will be provided at the Copayment when Medically Necessary and when taken in conjunction with smoking-cessation behavioral modification health classes.
- Emergency contraceptive pills will be provided at no charge.
- Drugs to shorten the duration of the common cold will not be covered.
- Requested special packaging (such as dose packaging) of drugs will not be covered.
- A 50-percent Copayment will apply to excluded drugs that Health Plan is required to provide under Prescription Continuity Coverage (California Health and Safety Code, Section 1367.22).
- Drugs in short supply from the manufacturer will be limited to less than a 100-day supply at the drug Copayment.
- Compounded drug products listed on our drug formulary or that include ingredients requiring a prescription by law will be provided at the brand name, $20 Copayment.

### Emergency Care Services

"Emergency Care Services" has been revised in the "Benefits" section.

### Post-Stabilization Care

This *DF/EOC* states that care received from non-Plan Providers in an emergency after the Member could, without medically harmful results, be moved to a facility designated by Health Plan is not covered. This is known as Post-Stabilization Care. In the past, Health Plan has not always enforced this provision. Beginning January 1, 2003, this provision will be enforced unless we authorize the Post-Stabilization Care.

### Exclusions

- A "Hair loss or growth treatment" exclusion has been added.
- The "Dental care" exclusion has been revised to indicate that certain dental Services to prepare the jaw or jawbone for radiation treatment are covered.

### Health education classes

Certain health education classes will be covered at no charge. These classes were previously provided for a reasonable charge or at the office visit Copayment.

### Hearing Services

The hearing aid allowance will be $2,500 per Medically Necessary aid, per ear, every 36 months. We will not provide the allowance if we have covered a hearing aid within the previous 36 months. Also, the allowance can only be used at the initial point of sale. If members do not use all of their allowance at point of sale, they cannot use it later. Members pay the difference between the allowance and the price of the hearing aid.

**Hospice care** in the "Benefits" section of this *DF/EOC* has been revised to comply with state law (AB 892).

### Vision Services

The supplemental Medicare optical/vision benefit will have a **$150 allowance** that may be applied every 24 months toward the purchase of covered lenses, frames, and/or cosmetic contact lenses. We will not provide the allowance if we have covered lenses or frames within the previous 24 months. Also, the allowance can only be used at the initial point of sale. If Members do not use all of their allowance at the point of sale, they cannot use it later. Members pay the difference between the allowance and the price of the eyewear.

The post-cataract surgery eyewear allowance has changed to **$150 per eye, per lifetime.**

### Senior Advantage capacity limitation

We will not be able to enroll new Members into the Kaiser Permanente Senior Advantage Plan if the applicant isn't already a Member and resides in an area that is subject to a capacity limitation approved by CMS. This limitation does not apply to enrolled Members who are newly eligible for Medicare, including when you turn 65.

### Administrative fee for billing for Copayments

Copayments are due when Health Plan provides Services or supplies to Members. The fee associated with billing Members for Copayments is increasing to $13.50 to reflect the actual cost of our billing process. It was previously $5.

### Dispute resolution

The "Dispute resolution" section has been revised for clarity.

### Binding arbitration

The "Binding arbitration" section has moved from "Section Three" and is included in the "Dispute resolution" section.

### Confidentiality

The "Medical confidentiality" section in "Section Three, Miscellaneous Provisions," has been revised and is now titled "Privacy practices."

### Notice to new enrollees about continuity of care

The "Notice to new enrollees about continuity of care" section has been revised to include acute, serious, or chronic psychiatric conditions.

### Terminology changes

A number of terms used in this *DF/EOC* have been added to the "Definitions" in "Section Three" for clarity.

# Benefit Summary and Copayments

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

### Copayments

Maximum Copayment limit for the 2003 calendar year:

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

| *Category* | *Copayment* |
|---|---|
| **Hospital inpatient care** | |
| Inpatient Services | $250 per admission |
| **Outpatient care** | |
| Primary and specialty care visits | $10 per visit |
| Allergy testing visits | $10 per visit |
| Allergy injection visits | $3 per visit |
| Blood and blood products | No charge |
| Immunization/Inoculation | No charge |
| Gynecological visits | $10 per visit |
| Scheduled prenatal care and the first postpartum visit | No charge |
| Pediatric visits | $10 per visit |
| Well-child preventive care visits (age 23 months or younger) | No charge |
| Routine physical exams | $10 per visit |
| Preventive health screenings, including colonoscopy and sigmoidoscopy | $10 per visit |
| Outpatient surgery | $10 per procedure |
| **Ambulance Services** | |
| | No charge |

| *Category* | *Copayment* |
|---|---|
| **Chemical dependency Services** | |
| Inpatient detoxification | $250 per admission |
| Outpatient individual therapy | $10 per visit |
| Outpatient group therapy | $5 per visit |
| Transitional residency recovery Services (up to 60 days per calendar year, not to exceed 120 days in any 5-year period) | $100 per admission |
| **Dialysis care** | |
| Inpatient care | $250 per admission |
| Physician office visits | $10 per visit |
| Dialysis treatment visits | No charge |
| **Drugs, supplies, and supplements** | |
| Drugs described in the "Benefits" section under the heading "Administered drugs and self-administered IV drugs" | No charge |
| Diabetes urine-testing supplies | No charge (up to a 100-day supply) |
| Certain insulin-administration devices | $10 generic/$20 brand name (up to a 100-day supply) |
| Drugs described in the "Benefits" section under the heading "Outpatient drugs, supplies, and supplements" | $10 generic/$20 brand name (up to a 100-day supply, or 3 cycles for oral contraceptives) |
| *Copayments for the following are as indicated:* | |
| Amino acid–modified products used to treat congenital errors of amino-acid metabolism and elemental dietary enteral formula when used as a primary therapy for regional enteritis | No charge (up to a 30-day supply) |
| Drugs related to the treatment of sexual dysfunction disorders: | |
| Episodic drugs are provided up to a supply maximum of 27 doses in any 100-day period | 50% of Charges (up to a 100-day supply) |
| Maintenance (nonepisodic) drugs that require doses at regulated intervals | 50% of Charges (up to a 100-day supply) |

| *Category* | *Copayment* |
|---|---|

## Drugs, supplies, and supplements *(continued)*

**Note:** *Quantities that exceed any supply maximum will be provided at Charges.*
**Limitation:** The day supply dispensed at the Copayment may be reduced (a) to a 30-day supply in any 30-day period for specific drugs (please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** for the current list of these drugs), or (b) if the pharmacy limits the amount dispensed because the drug is in limited supply in the market.

| *Category* | *Copayment* |
|---|---|

## Durable medical equipment (DME)

| | |
|---|---|
| Durable medical equipment used during a covered stay in a Plan Hospital or Skilled Nursing Facility | No charge |
| Durable medical equipment used in the home | No charge |

## Emergency Department visits

$50 per visit*

*Copayment waived if directly admitted to a hospital

## Family planning

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

## Health education

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

## Hearing

| | |
|---|---|
| Hearing test | $10 per visit |
| Hearing aid(s) every 36 months, as described in the "Benefits" section | Up to $2,500 allowance per ear, per aid |

## Home health care

No charge

| *Category* | *Copayment* |
|---|---|
| **Hospice care** | |
| Covered hospice care for Members not entitled to Medicare Part A | No charge |
| **Imaging, laboratory, and special procedures** | |
| | No charge |
| **Infertility Services** | |
| Inpatient and outpatient | Pay Copayments that apply to Services received. See the "Benefits" section for more information. |
| **Mental health Services** | |
| Inpatient psychiatric care | $250 per admission |
| Outpatient | $10 per visit |
| **Ostomy and urological supplies** | |
| | No charge |
| **Physical, occupational, and speech therapy, and multidisciplinary rehabilitation Services** | |
| Inpatient Services | No charge |
| Outpatient visits | $10 per visit |
| **Prosthetic and orthotic devices** | |
| Internally implanted devices | No charge |
| Covered external devices | No charge |
| **Reconstructive surgery** | |
| Inpatient Services | $250 per admission |
| Outpatient visits | $10 per visit |
| Outpatient surgery | $10 per procedure |

| *Category* | *Copayment* |
|---|---|
| **Skilled Nursing Facility care** | |
| (For up to 100 days per benefit period as defined by Medicare) | No charge |
| **Transplant Services** | |
| Inpatient Services | $250 per admission |
| Outpatient visits | $10 per visit |
| **Urgent care** | |
| In-area | $10 per visit at a Plan Facility; (not covered at a non-Plan Facility) |
| Out-of-Plan | $50 per visit if seen at a non-Plan Facility |
| **Vision Services** | |
| Eye refraction exam to determine the need for vision correction | $10 per visit |
| Eyeglasses | Frame and lens allowance once every 24 months. See the "Benefits" section for more information. |

# Welcome to Kaiser Permanente

Kaiser Permanente, a federally qualified health maintenance organization (HMO), has a contract with the Centers for Medicare & Medicaid Services (CMS) as a Medicare+Choice organization which is renewed annually. This contract provides Medicare Services through the Kaiser Permanente Senior Advantage Plan, except for hospice care for Members with Medicare Parts A and B and qualifying Clinical Trials, which are covered directly by Medicare.

### About this *Disclosure Form and Evidence of Coverage*

This *Disclosure Form and Evidence of Coverage (DF/EOC)* describes Senior Advantage coverage, including additional coverage provided in the *Group Agreement* between us and the University of California (your group). In this *DF/EOC,* Kaiser Foundation Health Plan, Inc., is sometimes called "Health Plan," "we," or "us." You, as an enrolled person, are sometimes called the "Member" or "you." Kaiser Permanente Senior Advantage Plan is sometimes called "Senior Advantage." Some capitalized terms have special meaning in this *DF/EOC.* Please see the "Definitions" section of "Section Three, General Information for All Members" for terms you should know. The term of this *DF/EOC* is January 1, 2003, through December 31, 2003.

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

Health Plan provides health care Services directly to its Members through an integrated medical care system, rather than reimbursing expenses on a fee-for-service basis. The *DF/EOC* should be read with this direct-service nature in mind. Also, if you have special health care needs, please read the applicable sections carefully. *Please read the following information so that you will know from whom or what group of providers you may obtain health care.*

## About Kaiser Permanente Senior Advantage

Kaiser Permanente Senior Advantage is for Members entitled to Medicare, providing the advantages of combined Medicare and Health Plan benefits. Senior Advantage provides all of the benefits provided by Medicare (except hospice care for Members with Medicare Parts A and B and qualifying Clinical Trials, which are covered directly by Medicare), and additional benefits not provided by Medicare.

As a Senior Advantage Member, you are selecting our medical care system to provide your health care. You must receive all covered care from Plan Providers inside our Service Area, except as described under the following headings:

- Emergency, Post-Stabilization, and urgent care" in this "Benefits" section;
- "Referrals to specialists" in the "How to Obtain Services" section;
- "Our visiting member program" in the "How to Obtain Services" section; and
- "Out-of-area dialysis care" in "Dialysis care" in the "Benefits" section.

Through our medical care program, you have convenient access to all of the covered health care Services you may need, such as routine care with your own personal Plan Physician, hospital care, nurses, laboratory and pharmacy Services, and other benefits described in the "Benefits" section.

## Who is eligible

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

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

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

### Eligibility requirements for Senior Advantage coverage

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

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

### ■ Persons terminated for cause or nonpayment

If you have ever had entitlement to receive Services through Health Plan terminated for any of the reasons listed under "Termination for cause" in the "Termination of Membership" section, you may not enroll until you have completed a Member orientation and have signed a statement promising future compliance with Health Plan rules. Also, if you have ever had entitlement to receive Services through Health Plan terminated for nonpayment of monthly Dues, you may not enroll until you pay the full amount owed to us.

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

## ■ Eligible Annuitants (including Survivor Annuitants)

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

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

### Enrollment of eligible Dependents

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

## ■ Eligible Dependents

**Spouse:** Your legal Spouse. Except if you are a Survivor Annuitant, you may not enroll your legal Spouse.

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

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

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

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

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

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

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

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

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

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

### Other eligible Dependents

You may enroll an adult dependent relative or same-sex domestic partner and his/her eligible children as set forth in the University of California Group Insurance Regulations. For information on who qualifies and on the requirements to enroll an adult dependent relative or same-sex domestic partner, contact the University of California's Customer Service Center.

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

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

**Note:** If necessary to maintain satisfactory service to existing Members, Kaiser Permanente may suspend enrollment of additional Members (except for newly eligible Spouse, newborns, newly eligible stepchildren, or newly adopted children and Senior Advantage enrollees).

## Enrollment

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

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

To enroll yourself and any eligible Dependents, you must complete a University of California Medicare Declaration form and a Kaiser Permanente Senior Advantage election form. This notifies the University that you are

covered by the hospital (Part A) and medical (Part B) parts of Medicare. Medicare Declaration forms and Kaiser Permanente Senior Advantage election forms are available through the University of California Customer Service Center and completed forms should be returned to them. Upon receipt by the University of confirmation of Medicare enrollment, the Annuitant/Dependent will be changed from the Kaiser Permanente Traditional Plan for non-Medicare enrollees to the Kaiser Permanente Senior Advantage Plan for Medicare enrollees. Annuitants and Dependents are required to transfer to the Plan for Medicare enrollees.

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

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

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

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

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

b. The effective date of retirement.

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

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

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

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

For newly adopted children, eligibility begins on the earlier of (i) the date the Annuitant or Annuitant's Spouse has the legal right to control the child's health care, or (ii) the date the child is placed in the Annuitant's custody. If not enrolled during the PIE, beginning on that date, there is a second PIE beginning on the date the adoption becomes final.

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

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

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

An Annuitant who currently has two or more covered Dependents may add a newly eligible Dependent after the PIE. Retroactive coverage for such enrollment is limited to the later of:

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

b. The date the Dependent became eligible.

## Special enrollment due to new Dependents

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

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

## Effective date of Senior Advantage coverage

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

If you will soon become entitled to both Medicare Parts A and B and submit a timely application, your election will be effective on the first day of the month in which you are entitled to both Medicare Parts A and B. If you are already entitled to both Medicare Parts A and B, we will notify you of your effective date. Your effective date will generally be determined by the date we receive your completed Election Form and the effective date of your group coverage. There are other factors used to determine your effective date, for more information please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

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

### Important information about Medicare supplement (Medigap) policies

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

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

- You are disenrolled from Senior Advantage because you moved out of our Service Area or for a reason that does not involve any fault on your part (such as Kaiser Permanente's contract with CMS terminates);
- You enrolled in Senior Advantage upon first reaching Medicare eligibility at age 65, and you disenroll from the Senior Advantage Plan within 12 months of your effective date;

- Your supplemental coverage under an employee welfare benefit plan terminates;
- Your enrollment in a Medigap policy ceases because of the bankruptcy or insolvency of the insurer issuing the policy, or because of other involuntary termination of coverage for which there is no state law provision relating to continuation of coverage; or
- You were previously enrolled under a Medigap policy and terminated your enrollment to participate, for the first time, in the Senior Advantage Plan and you disenroll during the first 12 months.

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

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

- Supplemental insurers (Medigap insurers) process their claims based on proof of an original Medicare payment, usually in the form of an Explanation of Medicare Benefits (EOMB). However, as long as you are a Member of the Senior Advantage Plan, original Medicare will not process any claims for medical Services you receive (except hospice care for Members with Medicare Parts A and B and qualifying Clinical Trials).
- Kaiser Permanente has the financial responsibility for all Medicare-covered health Services you need (except hospice care for Members with Medicare Parts A and B and qualifying Clinical Trials) as long as you follow the Senior Advantage Plan's procedures on how to receive medical Services.

### Coverage for Annuitants who are enrolling in conjunction with retirement

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

### Coverage for Annuitants or Dependents becoming eligible for Medicare

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

### Other situations

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

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

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

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

## Notice to new enrollees about continuity of care

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

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

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

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

## Dues

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

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

## Copayments

You will pay out-of-pocket Copayment amounts for certain benefits. These Copayments are due at the time of your visit. In some cases, we may agree to bill you for your Copayment. If we agree to bill you, we will increase the Copayment by $13.50 and mail you a bill for the entire amount.

There are limits to the total amount of Copayments you must pay in a calendar year for certain Services covered under this *DF/EOC*. The limits are $1,500 for one Member and $3,000 for two or more Members in one family.

Copayments for only the following covered Services apply toward these limits:

- Ambulance Services;
- Home health care;
- Hospital care;
- Imaging, laboratory tests, and special procedures;
- Out-of-Plan emergency, Post-Stabilization, and urgent care;
- Physical, occupational, respiratory, and speech therapy, and multidisciplinary rehabilitation Services; and
- Professional Services.

When you pay a Copayment for these Services, ask for and keep the receipt. When the receipts add up to the annual Copayment limit, call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** to find out where to submit your receipts. When you submit them, we will give you a card showing that you do not have to pay any more Copayments for the specified Services for the remainder of the calendar year.

# How to Obtain Services

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

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

- "Emergency, Post-Stabilization, and urgent care" in the "Benefits" section;
- "Referrals to specialists" in this section;
- "Our visiting member program" in this section; and
- "Out-of-area dialysis care" in "Dialysis care" in the "Benefits" section.

## Using your identification card

Each Member has a Health Plan ID card with a Medical Record Number on it, which is useful when you call for advice, make an appointment, or go to a provider for covered care. The Medical Record Number is used to identify your medical records and membership information. You should always have the same Medical Record Number. Please let us know if we ever inadvertently issue you more than one Medical Record Number by calling our Member Service Call Center. If you need to replace your card, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

Your ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed for any Services we provide. If you let someone else use your card, we may keep your card and terminate your membership.

## Plan Facilities

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

Plan Medical Offices and Plan Hospitals are listed in *Your Guidebook to Kaiser Permanente Services. Your Guidebook* includes information about the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services.

***Notice to Southern California Members:***

Please be aware that if a covered Service is not available at a Plan Facility, it will be made available to you at another Plan Facility. However, in accord with state law, we are required to include the following statement: "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, the medical group, independent practice association, clinic, or call the Kaiser Permanente Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** to ensure that you can obtain the health care Services that you need."

## Your primary care Plan Physician

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

## ■ A special note for Members in Coachella Valley and western Ventura County

***Southern California Members*** residing in Coachella Valley and western Ventura County are required to select a primary care Plan Physician. In these areas, Plan Providers are referred to as "Affiliated Providers," "Affiliated Physicians," and "Affiliated Specialty Physicians."

After enrollment, we will send a letter explaining how to select a primary care Affiliated Physician. If you do not select a primary care Affiliated Physician, we will assign one. You may change your primary care Affiliated Physician once a month.

Your primary care Affiliated Physician provides or arranges your care in these areas, including Services from other Affiliated Providers, such as Affiliated Specialty Physicians. For Services to be covered from other Affiliated Providers, your primary care Affiliated Physician must prescribe the care or authorize the referral, except for annual mammograms and visits to your Ob/Gyn Affiliated Physician which may be obtained directly without referral from your primary care Affiliated Physician.

If you need care before we have confirmed your primary care Affiliated Physician, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week,** for assistance. To learn about Affiliated Providers, please refer to the *Kaiser Permanente Facilities Guide* or the *Directory of Kaiser Permanente Affiliated Physicians for Coachella Valley and western Ventura County.* Copies of directories can be obtained by calling our Member Service Call Center.

Please refer to "Service Area" in "Section Three" of this booklet for the ZIP codes that are in these two areas. You may receive care from an Affiliated Physician even if you don't live in these areas. If you do live in one of these areas, you may receive care from Plan Providers in other parts of our Service Area that are not in these two areas.

## Second opinions

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

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

To get a second opinion, you can either ask your Plan Physician to help you arrange for a second medical opinion, or you can make an appointment with another Plan Provider. If the Medical Group determines that there isn't a Plan Provider who is an appropriately qualified health care professional for your condition, the Medical Group will authorize a

referral to a non-Plan Provider for a Medically Necessary second opinion. Copayments for these referral Services are the same as those required for Services provided by a Plan Provider.

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

***Northern California Members*** residing in Stanislaus County may arrange for a second medical opinion by a Plan Physician by calling our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

***Southern California Members,*** if you live in Coachella Valley or western Ventura County and wish to obtain a second opinion from another Affiliated Physician, your designated primary care Affiliated Physician must arrange the second medical opinion.

## Contracts with Plan Providers

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

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

**Termination of a Plan Provider's contract.** If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care you receive from that provider, in excess of any applicable Copayments, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

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

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

The Services must be otherwise covered under this *DF/EOC.* Also, the terminated provider must agree in writing to our contractual terms and conditions and comply with them for Services to be covered by the Medical Group.

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

## Getting the care you need

You are covered for medical emergencies anywhere in the world. Emergency Care is provided at Plan Hospitals 24 hours a day, seven days a week. If you think you have a medical or a psychiatric emergency, call 911 or go to the nearest hospital. For coverage information about non-Plan Emergency Care, refer to "Emergency, Post-Stabilization, and urgent care" in the "Benefits" section.

You may also get medical advice by telephone. Advice nurses are RNs specially trained to help assess medical problems and provide advice. They can help solve a problem over the phone and instruct you on self-care at home, if appropriate. If the problem is more severe and you need an appointment to be seen, they will help schedule one. For information about Out-of-Area Urgent Care, refer to "Emergency, Post-Stabilization, and urgent care" in the "Benefits" section.

Refer to *Your Guidebook to Kaiser Permanente Services* for nonemergency appointment information. If you don't have *Your Guidebook,* call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** to request one.

## Referrals to specialists

Plan Physicians offer primary medical, pediatric, obstetrics, and gynecology care as well as specialty care in areas such as surgery, orthopedics, cardiology, oncology, urology, and dermatology. A Plan Physician will refer you to a Plan specialist when appropriate. However, you can receive care from Plan Physicians in the following specialties without a referral: internal medicine, obstetrics/gynecology, family practice, pediatrics, optometry, psychiatry, and chemical dependency. Please refer to your facility's listing in *Your Guidebook* for the departments that do not require a referral.

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 review the request to determine if the Service is Medically Necessary and whether it is available from a Plan Provider. The Medical Group must authorize the referral in writing in order for us to cover the Services. Copayments for these referral Services are the same as those required for Services provided by a Plan Provider. Please refer to "Second opinions" in this section for information about obtaining a second opinion from a non-Plan Provider.

## Our visiting member program

If you visit the service area of another Region temporarily (not more than 90 days), you can receive certain Services as a visiting member from designated providers in that area. The covered Services, supplies, and Copayments may differ from those under this *DF/EOC* and are governed by our visiting member program. This program does not cover certain Services, such as transplants or infertility Services. Except for covered Emergency Care and Out-of-Area Urgent Care, your right to receive Services in the visited service area ends after 90 days, unless you receive prior written authorization from us to continue receiving covered Services in the visited service area.

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

## Moving outside our Service Area

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

***Northern California Members:***

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

***Southern California Members:***

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

## Moving to another Service Area

If you move to the Senior Advantage Plan service area of another Region, you should contact your group's benefits administrator to learn about your group health care options. You may be able to continue or transfer your group membership, if there is an arrangement with your group that permits membership in the new service area and you meet the eligibility requirements. The benefits, Copayments, Dues, and eligibility requirements may not be the same in the new service area. The service area where you may apply and enroll can change at any time.

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

# Benefits

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

- A Plan Physician determines that the Services are Medically Necessary to prevent, diagnose, or treat your medical condition. A Service is Medically Necessary only if a Plan Physician determines that it is medically appropriate for you and its omission would adversely affect your health.
- The Services are provided, prescribed, authorized, or directed by a Plan Physician.
- You receive the Services at a Plan Facility or Skilled Nursing Facility within our Service Area, except where specifically noted to the contrary in the following sections about:
  - "Referrals to specialists" in the "How to Obtain Services" section;
  - "Our visiting member program" in the "How to Obtain Services" section;
  - Emergency Care and Out-of-Area Urgent Care received from non-Plan Providers, in "Emergency, Post-Stabilization, and urgent care", in this "Benefits" section;

- "Out-of-area dialysis care" in this "Benefits" section:
- House calls in this "Benefits" section; and
- "Hospice care" in this "Benefits" section.

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

- "Emergency, Post-Stabilization, and urgent care" in this "Benefits" section for information about how to obtain Emergency Care and urgent care.
- This "Benefits" and "Benefit Summary and Copayments" sections for the Copayments you must pay for covered Services.
- *Your Guidebook to Kaiser Permanente Services* for the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services.

## Hospital inpatient care

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

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

  **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge.
- Respiratory therapy; and
- Medical social Services and discharge planning.

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

- "Chemical dependency services"
- "Dialysis care"
- "Drugs, supplies, and supplements"
- "Durable medical equipment (DME)"
- "Emergency, Post-Stabilization, and urgent care"
- "Hospice care"
- "Imaging, laboratory, and special procedures"
- "Infertility Services"
- "Mental health Services"
- "Ostomy and urological supplies"
- "Physical, occupational, and speech therapy, and multidisciplinary rehabilitation Services"
- "Prosthetic and orthotic devices"
- "Reconstructive surgery"

- "Services associated with Clinical Trials"
- "Skilled Nursing Facility care"
- "Transplant Services"

## Outpatient care

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

- Primary care visits for internal medicine, gynecology (including cervical cancer screening tests and mammograms), family practice, and pediatrics;
- Specialty care visits, including consultation and second opinions with Plan Physicians in departments other than those listed as primary care visits above;
- Allergy testing;
- Outpatient surgery;
- Respiratory therapy visits;
- Preventive health screenings; and
- Post-transplant care.

***Northern California Medicare Members:***

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

***Southern California Medicare Members:***

- Manual manipulation of the spine to correct subluxation, as covered by Medicare, is provided by an American Specialty Health Plans of California, Inc. (ASH Plans) participating chiropractor. A referral by a Plan Physician is not required. For the list of participating ASH Plans providers, please refer to the ASH Plans provider directory. To request an ASH Plans provider directory, call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

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

- Allergy injections.

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

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

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

- "Ambulance Services"
- "Chemical dependency Services"
- "Dialysis care"
- "Drugs, supplies, and supplements"
- "Durable medical equipment (DME)"
- "Emergency, Post-Stabilization, and urgent care"
- "Family planning Services"
- "Health education"
- "Hearing Services"
- "Home health care"
- "Hospice care"
- "Imaging, laboratory, and special procedures"
- "Infertility Services"
- "Mental health Services"

- "Ostomy and urological supplies"
- "Physical, occupational, and speech therapy, and multidisciplinary rehabilitation Services"
- "Prosthetic and orthotic devices"
- "Reconstructive surgery"
- "Religious nonmedical health care institution Services"
- "Transplant Services"
- "Vision Services"

## Ambulance Services

We cover the emergency Services of a licensed ambulance at **no charge.** We cover emergency ambulance Services that are not ordered by us if you reasonably believe all of the following:

- You are experiencing 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, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part; and
- Your condition requires ambulance transportation.

We also cover nonemergency ambulance Services for transportation if, in the judgment of a Plan Physician, your condition requires the use of medical Services that only a licensed ambulance can provide and the use of other means of transportation would endanger your health.

### ■ Ambulance Services exclusions

Transportation by car, taxi, bus, gurney van, wheelchair van, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider, is not covered.

## Chemical dependency Services

**Inpatient detoxification**

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

**Outpatient**

We cover the following Services for treatment of chemical dependency:

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

  **$10 per individual therapy visit**

  **$ 5 per group therapy visit**

- We cover methadone maintenance treatment at **no charge** for pregnant Members during pregnancy, and for two months after delivery, at a licensed treatment center approved by 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 care in a nonmedical transitional residential recovery setting approved in writing by the Medical Group at **$100 per admission;** no more than 120 days of covered care is provided in any five-consecutive-calendar-year period. These settings provide counseling and support Services in a structured environment.

## ■ Chemical dependency Services exclusions

- We do not cover Services in a specialized facility for alcoholism, drug abuse, or drug addiction, except as described above.
- We will discontinue counseling or treatment if you are disruptive or physically abusive.

## Clinical Trials

Original Medicare will pay for certain Services related to qualifying Clinical Trials. **This is not a Kaiser Permanente benefit.** You should continue to come to Plan Providers for all covered Services that are not part of the Clinical Trial, except as described under the following headings:

- "Referrals to specialists" in the "How to Obtain Services" section.
- "Our visiting member program" in the "How to Obtain Services" section.
- "Out-of-Area dialysis care" in the "Dialysis care" section.
- "Emergency, Post-Stabilization, and urgent care" in this "Benefits" section.

Medicare will pay for many, but not all, Services associated with qualifying Clinical Trials. You should ask the Clinical Trial provider if the Clinical Trial qualifies for Medicare payments and what Medicare coinsurance and other out-of-pocket expenses you will have to pay for related Services. Original Medicare does not require that you get a referral from a Plan Physician to join a qualifying Clinical Trial. However, you should tell us before you join a Clinical Trial outside of Kaiser Permanente so we can keep track of your health care Services. For more information on Medicare payments for Clinical Trials and which Clinical Trials qualify, please call Medicare directly at **1-800-MEDICARE (1-800-633-4227) (1-877-486-2048 TDD).**

## Dialysis care

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

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

**Inpatient care: $250 per admission**

**Outpatient care: $10 per visit**

**Dialysis treatment: No charge**

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

### Out-of-area dialysis care

We cover dialysis for end-stage renal disease at a Medicare-certified facility that is needed while you are traveling temporarily outside our Service Area. There is no limit to the number of covered routine dialysis days. Although it's not required, we ask that you contact us before you leave our Service Area so we can coordinate your care when you are temporarily outside our Service Area. Please refer to your ESRD patient material for more information.

**Note:** The procedure for obtaining reimbursement for out-of-area dialysis care is described in the "Getting Assistance, Filing Claims, and Dispute Resolution" section.

## Drugs, supplies, and supplements

We cover drugs, supplies, and supplements specified below when prescribed by a Plan Physician (except as otherwise described under "Outpatient drugs, supplies, and supplements") and in accord with our drug formulary guidelines. Also, you must obtain covered drugs, supplies, and supplements from a Plan Pharmacy or another pharmacy that we designate. It may be possible for you to receive refills by mail; ask for details at our pharmacy.

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

### ■ Administered drugs and self-administered IV drugs

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

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

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

### ■ Diabetes urine-testing supplies and certain insulin-administration devices

We cover the following diabetes urine-testing supplies:

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

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

We cover the following insulin-administration devices:

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

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

### ■ Outpatient drugs, supplies, and supplements

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

We cover at **$10 generic/$20 brand name per prescription for up to a 100-day supply*:**

- Drugs for which a prescription is required by law. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary.
- Smoking-cessation drugs are covered if you participate in a Plan-approved behavior intervention program.

- Diaphragms, cervical caps, and oral contraceptives.
- Disposable needles and syringes needed for injecting covered drugs.

* Prescription drug quantities that exceed a 100-day supply will be provided at Charges, not the Copayment.

**Note:** If the Copayment is greater than Charges for a prescription, the Member pays the lower amount. The Charges is the amount a Member would pay for the prescription if the Member's benefit plan did not cover prescription drugs.

We cover the following at **50 percent of Charges:**

- Drugs for diagnosis and treatment of infertility.

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

- Episodic drugs, as prescribed by a Plan Physician, will be provided up to a maximum of **27 doses in any 100-day period at 50 percent of Charges. Additional prescribed doses that exceed the dose maximum during the same 100 days will be dispensed at Charges.**
- Maintenance (nonepisodic) drugs, as prescribed by a Plan Physician, that require doses at regulated intervals will be provided at **50 percent of Charges for up to a 100-day supply. Quantities in excess of a 100-day supply will be provided at Charges.**

## ■ Special note 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. Our drug formulary guidelines allow you to obtain prescription drugs that are not listed on the drug formulary for your condition if a Plan Physician determines that they are Medically Necessary. Also, our formulary guidelines may require you to participate in a Plan-approved behavioral intervention program for specific conditions, and you may be required to pay for the program. If you would like information about whether a particular drug is included in our drug formulary, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

**Note:** If a drug for which a prescription is required by law is no longer covered and we had been covering and providing it to you for a use approved by the FDA, we will continue to provide the drug upon payment of a 50-percent Copayment if a Plan Physician continues to prescribe the drug for the same condition.

## ■ Drugs, supplies, and supplements exclusions

- Any drugs, supplies, and supplements needed in connection with a Service that is not covered under this *DF/EOC.*
  - Compounded products, unless the product is listed on the drug formulary, or one of the ingredients requires a prescription by law.
  - Drugs to shorten the duration of the common cold.
  - Any requested packaging (such as dose packaging), other than the dispensing pharmacy's standard packaging.

## Durable medical equipment (DME)

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

We cover durable medical equipment as prescribed by a Plan Physician for use in your home (or an institution used as your home). We also cover equipment, including oxygen-dispensing equipment and oxygen used during a covered stay in a Plan Hospital or a Skilled Nursing Facility, if a Skilled Nursing Facility ordinarily furnishes the equipment.

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 for the equipment when we are no longer covering it.

**Note:** Diabetes urine-testing supplies and other insulin-administration devices are not covered under this section (refer to "Drugs, supplies, and supplements").

### ■ Durable medical equipment exclusions

We do not cover:

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

## Emergency, Post-Stabilization, and urgent care

### ■ Emergency Care

We cover Emergency Care from Plan Providers and non-Plan Providers anywhere in the world. Emergency Care is Medically Necessary ambulance Services and evaluation by appropriate medical personnel to determine if an Emergency Medical Condition exists. If one exists, Emergency Care is also the Medically Necessary care, treatment, and surgery required to stabilize your Emergency Medical Condition (make you Clinically Stable) within the capabilities of the facility.

**Note:** Please refer to "Ambulance Services" in this section for information about ambulance coverage.

An Emergency Medical Condition is a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain), such that you could reasonably expect the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to your health.
- Serious impairment in your bodily functions.
- Serious dysfunction of any bodily organ or part.

An Emergency Medical Condition is also "active labor," which means a labor when there is inadequate time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the Member or unborn child.

If you think you have an Emergency Medical Condition, call 911 or go to the nearest hospital. To better coordinate your Emergency Care, we recommend that you go to a Plan Hospital if it is reasonable to do so considering your condition or symptoms. Please refer to *Your Guidebook* for the location of Plan Hospitals that provide Emergency Care.

**Emergency Care: $50 per visit** (charge waived if admitted to hospital)

## ■ Post-Stabilization Care

Post-Stabilization Care is the Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable. We cover Post-Stabilization Care if a Plan Provider provides it or if you obtain authorization from us to receive the care from a non-Plan Provider.

To request authorization for Post-Stabilization Care, you must call us 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 and decide whether to authorize your care from the non-Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. Please ask the non-Plan Provider whether we authorized your Post-Stabilization Care.

Please refer to "Call us for non-Plan admissions or Post-Stabilization Care authorization" on this page for the telephone number to call and additional information about notification requirements.

## ■ 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.

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

**Out-of-Area Urgent Care at non-Plan Facilities:**

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

**$50 per visit, if seen in an emergency room**

## ■ Additional coverage limitations

**Call us for non-Plan admissions or Post-Stabilization Care authorization.** You must call us at **1-800-225-8883** (the telephone number to call is also on your ID card) to:

- Request authorization for Post-Stabilization Care *before* you obtain the care from a non-Plan Provider if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible).
- Notify us that you have been admitted to a non-Plan Hospital. You must notify us within 24 hours of any admission or as soon as reasonably possible. We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you don't notify us as soon as reasonably possible, we will not cover any Services you receive after transfer would have been possible.

**Note:**

- We know that extraordinary circumstances can delay your ability to call us, for example if you are unconscious or a young child without a parent or guardian. In these cases, you must call us as soon as it is reasonably possible. Please keep in mind that anyone can call us. If you don't call us when it becomes possible for you to call, you may be financially responsible for the cost of the unauthorized Services received after you became Clinically Stable.

### ■ Reimbursement for non-Plan Emergency and Out-of-Area Urgent Care received from non-Plan Providers

Continuing or follow-up treatment is not covered, except as discussed above. Our reimbursement will be reduced by applicable Copayments, which are the same Copayments required for Services provided by a Plan Provider.

The procedure for obtaining reimbursement for Emergency Care and Out-of-Area Urgent Care received from non-Plan Providers is described in the "Filing claims" section.

## Family planning Services

We cover:

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

**Inpatient Services: $250 per hospital inpatient admission**

**Outpatient visits: $10 per visit**

**Note:**

- Diagnostic procedures are not covered under this section. See "Imaging, laboratory, and special procedures" in this "Benefits" section.
- Contraceptive drugs and devices are not covered under this section. See "Drugs, supplies, and supplements" in this "Benefits" section.

### ■ Family planning Services exclusions

We do not cover Services to reverse voluntary, surgically induced infertility.

## Health education

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

**Individual visits: $10 per visit**

**All other covered Services: No charge**

## Hearing Services

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

**Hearing aid(s).** We cover the following:

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

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

### ■ Hearing Services exclusions

We do not cover:

- Replacement parts and batteries;
- Replacement of lost or broken hearing aids,
- Repair of hearing aids after the warranty period;
- Internally implanted hearing aids;
- Comfort, convenience, or luxury equipment or features; and
- Hearing aids prescribed or ordered before the effective date or after the termination date of your coverage.

## Home health care

We cover the following home health care Services at **no charge:**

- Only within our Service Area;
- Only if you are substantially confined to your home; and
- Only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home.

Home health care Services are Medically Necessary health Services that can be safely and effectively provided in your home by health care personnel, prescribed by a Plan Physician, and directed by our Home Health Committee, which is comprised of Plan Physicians and other health care professionals.

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

- "Drugs, supplies, and supplements"
- "Durable medical equipment (DME)"
- "Ostomy and urological supplies"
- "Physical, occupational, and speech therapy, and multidisciplinary rehabilitation Services"
- "Prosthetic and orthotic devices"

### ■ Home health care exclusions

Home health Services do not include:

- Custodial care (see definition under "Exclusions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section), and homemaker Services; and
- Care that the Home Health Committee determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, and we provide or offer to provide that care in one of these facilities.

## Hospice care

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

We cover the Services listed below only if all of the following requirements are met:

- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less;
- The Services are provided inside our Service Area by a licensed hospice agency approved by the Medical Group; and
- The Services are necessary for the palliation and management of your terminal illness and related conditions.

If all of the above requirements are met, we cover the following hospice Services at **no charge,** which are available on a 24-hour basis to the extent necessary for your hospice care:

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

### ■ Hospice care exclusions

We do not cover hospice care for Members with Medicare A and B. For those Members, if your Plan Physician determines you are eligible for and you wish to elect hospice care, we will assist you in identifying Medicare-certified hospices, including any Kaiser Permanente hospice, in your area. The hospice will bill Medicare directly for the care ordered by the hospice team. In addition, the hospice may charge you 5 percent of the reasonable cost of outpatient drugs or biologicals for pain relief and

symptom management (up to a maximum of $5 for each prescription). The hospice may also charge you approximately $5 for each day of inpatient respite care.

**Note:** If you elect hospice care, you are not entitled to any other benefits for the terminal illness under this *Agreement* that are not related to the terminal illness. You may change your decision to receive hospice care at any time.

## Imaging, laboratory, and special procedures

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

- Diagnostic and therapeutic imaging;
- Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available;
- Special procedures such as electrocardiograms and electroencephalograms; and
- Ultraviolet light treatment.

We cover the following Services at **50 percent of Charges:**

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

## Infertility Services

We cover the following Services:

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

**Inpatient Services: $250 per hospital inpatient admission**

**Outpatient Services: $10 per visit**

**Note:**

- Drugs, supplies, and supplements are not covered under this section. See "Drugs, supplies, and supplements" in this "Benefits" section.
- Diagnostic procedures are not covered under this section. See "Imaging, laboratory, and special procedures" in this "Benefits" section.

## ■ Infertility Services exclusions

We do not cover Services to reverse voluntary, surgically induced infertility.

## Mental health Services

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

- Serious emotional disturbances of a child as defined in Section 1374.72(e) of the California Health and Safety Code.
- 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.

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

### Outpatient mental health Services

We cover, at **$10 per visit:**

- Diagnostic evaluation and psychiatric treatment;

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

### Inpatient psychiatric care

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

### Hospital alternative Services

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

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

## Ostomy and urological supplies

Within our Service Area, we cover ostomy and urological supplies prescribed in accord with our durable medical equipment (DME) formulary guidelines, during a covered stay in a Plan Hospital or Skilled Nursing Facility, in Plan Medical Offices and Plan Hospital Emergency Departments, and for home use at **no charge.** Coverage is limited to the standard item of equipment that adequately meets your medical needs.

### ■ Ostomy and urological supplies exclusions

We do not cover comfort, convenience, or luxury equipment or features.

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

### ■ Physical, occupational, and speech therapy

If a Plan Physician determines that significant improvement is achievable, we will cover prescribed courses of physical, occupational, and speech therapy in a Plan Facility or Skilled Nursing Facility or as part of home health care.

**Inpatient Services: No charge**

**Outpatient visits: $10 per visit**

### ■ Limitations

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

### ■ Multidisciplinary rehabilitation Services

If, in the judgment of a Plan Physician, significant improvement in function is achievable, we will cover treatment in a prescribed, organized, multidisciplinary rehabilitation program in a Plan Facility or Skilled Nursing Facility.

**Inpatient Services: No charge**

**Outpatient visits: $10 per visit**

## Prosthetic and orthotic devices

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

your medical needs. We also cover enteral formula for Members who require tube feeding in accord with Medicare guidelines.

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

## ■ Internally implanted devices

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

## ■ External devices

We cover the following external 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 (including electronic voice-producing devices for Medicare Members only);
- Prostheses needed after a covered mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres every 12 months;
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan podiatrist, physiatrist, or orthopedist;
- Compression burn garments and lymphedema wraps and garments; and
- Other covered prosthetic and orthotic devices:
  - Prosthetic devices required to replace all or part of an organ or extremity, or the function of either;
  - Rigid and semi-rigid orthotic devices required to support or correct a defective body part; and
  - Special footwear for foot disfigurement due to disease, injury, or developmental disability.

## ■ Prosthetic and orthotic devices exclusions

We do not cover:

- Eyeglasses and contact lenses;
- Hearing aids under this benefit (please see "Hearing Services" in this "Benefits" section);
- Dental appliances;
- Except as indicated on the previous page, nonrigid supplies such as elastic stockings and wigs;
- Comfort, convenience, or luxury equipment or features;
- Electronic voice-producing machines; and
- Shoes or arch supports, even if custom-made, unless as indicated on the previous page.

# Reconstructive surgery

We cover reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Plan Physician determines that it is necessary to improve function or create a normal appearance, to the extent possible.

## ■ Mastectomies

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

**Inpatient Services: $250 per admission**

**Outpatient visits: $10 per visit**

### ■ 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; and
- Prosthetic and orthotic devices are covered only as described under "Prosthetic and orthotic devices" in this "Benefits" section.

## Religious Nonmedical Health Care Institution Services

Certain Services in a Medicare-certified Religious Nonmedical Health Care Institution (RNHCI) are covered under the Kaiser Permanente Senior Advantage Plan. However, religious aspects of care provided in a RNHCI are not covered. If you want to receive care in a RNHCI, please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** as there are certain requirements you must satisfy.

## Skilled Nursing Facility care

Within our Service Area, we cover up to 100 days per "benefit period" of Medically Necessary skilled inpatient Services prescribed by a Plan Physician in a licensed Skilled Nursing Facility. The skilled inpatient Services must be customarily provided by Skilled Nursing Facilities and above the level of custodial or intermediate care. A benefit period begins on the date you are admitted to a hospital or to a Skilled Nursing Facility at a skilled level of care (defined in accord with Medicare guidelines).

A benefit period ends on the date you have:

1. Not been an inpatient in a hospital or a Skilled Nursing Facility for 60 consecutive days; or
2. Not received a skilled level of care in a Skilled Nursing Facility for 60 consecutive days.

A prior three-day stay in an acute-care hospital is not required.

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

- Physician and nursing Services;
- Room and board;
- Medical social Services;
- Blood, blood products, blood transfusions, and their administration;
- Equipment described under "Durable medical equipment (DME)," and oxygen;
- Medical supplies;
- Respiratory therapy;
- Drugs covered under "Drugs, supplies, and supplements" in this "Benefits" section;
- Procedures covered under "Imaging, laboratory, and special procedures" in this "Benefits" section; and
- Services covered under "Physical, occupational, and speech therapy, and multidisciplinary rehabilitation Services" in this "Benefits" section.

### ■ Home Skilled Nursing Facility

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

- The Skilled Nursing Facility where you were residing at the time of your hospital admission;

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

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

## Transplant Services

We cover transplants of organs, tissue, or bone marrow, when a Plan Physician provides a written referral for care to a transplant facility as described in "Referrals to specialists," 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; and
- In accord with our criteria for donor Services, we provide certain donation-related Services for a donor, or an individual identified by the Medical Group as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. Our criteria for donor Services are available by calling our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

**Inpatient Services: $250 per admission**

**Outpatient visits: $10 per visit**

### ■ Transplant Services exclusions

We do not cover Services related to nonhuman or artificial organs and their implantation.

## Vision Services

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

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

### ■ Optical Services

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

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

**Special contact lenses.** We cover the following special contact lenses when prescribed by a Plan Physician or Plan optometrist:

- We will provide up to two contact lenses per eye every 12 months to treat aniridia (missing iris).
- We will provide up to five aphakic contact replacement lenses per eye under this or any other *DF/EOC* for children from birth through age 9 (aphakia is the absence of the crystalline lens of the eye).
- If contact lenses will provide a significant improvement in your vision not obtainable with eyeglass lenses, we cover one pair of contact lenses and their fitting and dispensing every 24 months. When we cover these special contact lenses, you cannot use the allowance mentioned in "Eyeglasses and contact lenses following cataract surgery" for another 24 months. However, if the combination of special contact lenses and eyeglasses will provide a significant improvement in your vision not obtainable with special contact lenses alone, you can use that allowance toward the purchase of the eyeglasses if we have not covered lenses or frames within the previous 24 months. If you have a change in prescription of at least .50 diopter in one or both eyes, we will cover special contact lens replacements, including fitting and dispensing.

**Eyeglasses and contact lenses following cataract surgery.** In accord with Medicare guidelines, we provide a **$150 allowance** for each affected eye to pay for eyeglass lenses, frames, and contact lenses, fitting, and dispensing. The allowance applies to each affected eye following cataract surgery and is provided once per lifetime. Also, the allowance can only be used at the initial point of sale. If you do not use all of your allowance for one eye at the initial point of sale, you cannot use it later.

## ■ Vision Services exclusions

We do not cover:

- Glass eyeglass lenses;
- Industrial and athletic safety lenses and frames;
- Sunglasses without corrective lenses, unless Medically Necessary;
- Blended bifocals and trifocals;
- Scratch coating;
- Ultraviolet inhibiting lenses;
- Cosmetic contact lenses;
- Lens adornment, such as engraving, faceting, or jeweling;
- Tinted lenses or other special-use lenses such as polarized, polycarbonate, photochromic, or anti-reflective lenses, unless the lenses are Medically Necessary to treat macular degeneration or retinitis pigmentosa;
- Progressive multifocal lenses and high-index lenses;
- All Services related to eye surgery that are solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), far-sightedness (hyperopia), and astigmatism;
- All Services relating to contact lenses including examinations, fitting, and dispensing, unless the contact lenses are covered following cataract surgery or are medically required as defined in this section;
- Replacement of lost or broken lenses or frames;
- Low-vision devices; and
- New prescription products, such as eyeglass holders, cases, and repair kits.

# Exclusions, Limitations, Coordination of Benefits, and Reductions

## Exclusions

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

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

1. Required for obtaining or maintaining employment or participation in employee programs, or
2. Required for insurance or licensing, or
3. On court order or required for parole or probation.

This exclusion does not apply if a Plan Physician determines that the Services and supplies are Medically Necessary.

- **Chiropractic Services,** except as covered by Medicare. Manual manipulation of the spine, when prescribed by a Medical Group or Plan Physician, is provided to Medicare Members under this *DF/EOC.* Please see "Outpatient care" in the "Benefits" section.
- **Conception by artificial means.** All Services (other than artificial insemination described under "Infertility Services") related to conception by artificial means, such as but not limited to 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.** Plastic surgery or other cosmetic Services that are intended primarily to improve your appearance, except for Services covered under "Reconstructive surgery" in the "Benefits" section.
- **Custodial care.** Custodial care means:

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

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

- **Dental care.** Dental care and dental X-rays, such as dental Services following accidental injury to teeth, dental appliances, dental implants, orthodontia, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment. This exclusion

does not apply to evaluation, extraction, dental X-rays, or fluoride treatment, if a Plan Physician refers you to a dentist (as described under "Referrals to specialists") to prepare your jaw for radiation treatment of cancer. This exclusion does not apply to Medically Necessary care covered under Medicare.

- **Experimental or investigational Services.** A Service is experimental or investigational if we, in consultation with the Medical Group, determine that:

1. Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients); or
2. 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 "Clinical Trials" in this "Benefits" section.

- **Hair loss or growth treatment.** Services for promotion, prevention, or other treatment of hair loss or hair growth.
- **Intermediate care.** Care in a licensed, intermediate care facility. This exclusion does not apply to Services covered under "Hospice care" in the "Benefits" section.
- **Routine foot care Services.** Routine foot care Services that are not Medically Necessary.
- **Services not available in our Service Area.** Services not generally and customarily available in our Service Area except when it is generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.
- **Sexual reassignment surgery.**
- **Surrogacy.** Services for anyone in connection with a surrogacy arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. Also, Services related to conception by artificial means related to a surrogacy arrangement. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. Please refer to "Surrogacy arrangements" in "Section One, Reductions" for information about your obligations to us in connection with a surrogacy arrangement, including your obligation to reimburse us for any Services we cover.
- **Transportation and lodging expenses.** Transportation and lodging expenses for any person, including a Member. However, in some situations, if we refer you to a non-Plan Provider as described under "Referrals to specialists" in the "How to Obtain Services" section, we may preauthorize certain expenses in accord with our travel and lodging policy and so notify you. An example of a situation where we would authorize such expenses is if we were to refer a Member outside of California to receive covered care that is not available from any provider within the state.

## Limitations

- We will use our best efforts 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 of a Plan Facility, complete or partial destruction of facilities, and labor

disputes not involving Health Plan, Kaiser Foundation Hospitals, or the Medical Group. However, Health Plan, Kaiser Foundation Hospitals, the Medical Group, and the Medical Group Physicians will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or the Medical Group we may postpone routine or elective care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences in the judgment of a Plan Physician.

- If you believe you are entitled to alternative Services covered by Medicare, you have the right to receive a determination in writing and to appeal any decisions under the procedures described in the "Getting assistance, filing claims, and dispute resolution" section (except for disputes related to the coverage of hospice care for Members entitled to Medicare Parts A and B or qualifying Clinical Trials).

## Coordination of benefits (COB) for the Senior Advantage Plan

In certain cases, this *DF/EOC* is subject to coordination of benefits. COB applies when you have health benefits coverage through more than one health care plan and one of them is group coverage that is subject to Medicare secondary payer law. If federal law requires that a group's coverage be primary and Medicare coverage be secondary, we or the other health care plan will coordinate benefits with the plan whose group coverage is primary by law. We will ask if you have other coverage. If you have other health care plan coverage, you must help us obtain payment from them by providing the information we request. The following are situations when Medicare is secondary for the purposes of COB:

- If you are age 65 or older and have group health care coverage through an employer with 20 or more employees, either through your or your Spouse's current employment (this applies to most employers with 20 or more employees).
- If you are under age 65 and entitled to Medicare due to disability and have coverage under a large employer group health plan (100 or more employees), either through your own employment or the employment of a family member.
- If you become eligible for, or entitled to, Medicare based on end-stage renal disease (ESRD) and are covered by an employer group health plan, you will be subject to a 30-month benefit coordination period, during which time Medicare is secondary payer, if: (1) ESRD is the sole basis for your Medicare eligibility or entitlement, (2) you also become eligible for or entitled to Medicare based on age or disability during the first 30 months of your ESRD-based eligibility or entitlement, or (3) you are entitled to Medicare based on age or disability and are subject to Medicare secondary payer provisions (refer to the first two bullets above).

## Reductions

### ■ Medicare benefits

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

### ■ Medicare as secondary payer

**Auto and liability insurance.** When Medicare by law is the secondary payer, federal law authorizes health plans to seek reimbursement from the medical expense provisions of any motor vehicle insurance covering you, and any

liability insurance that provides payment for injuries or illness to you. We will reduce your benefits under this *DF/EOC* by all amounts paid or payable under your other health plan or insurance policy. You must complete and submit to us all consents, releases, assignments, and other documents necessary for us to obtain or assure such payment. If you fail to do so, then we may, at our discretion, require you to pay the Charges for Services.

**See Addendum on page 155 for the following additional Reductions for "Section Two, Senior Advantage Plan:"**

- Employer responsibility.
- Government agency responsibility.
- Workers' compensation or employer's liability benefits.

# Getting Assistance, Filing Claims, and Dispute Resolution



## Getting assistance

Most Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining medical Services. At different Plan Hospitals these offices may be called Patient Assistance, Member Service, or Customer Service offices. In addition, we have Member Service Call Center representatives who are available from 7 a.m. to 7 p.m., seven days a week. Members may call toll free at **1-800-464-4000 (1-800-777-1370 TTY),** for help with questions or concerns. Member Service representatives, dedicated to assisting Medicare Members, staff the **1-800-464-4000** line from 7 a.m. to 7 p.m., Monday through Friday, and from 7 a.m. to 3 p.m. on Saturday.

Member Service representatives at our Plan Facilities and Member Service Call Center can answer 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 traveling, and how to replace an ID card. These representatives can also help you if you need to file a claim for out-of-Plan emergency care (including Post-Stabilization Care), out-of-Plan urgent care, or out-of-area dialysis care, and they can help you with any complaints or initiate a grievance for any type of unresolved issue.

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have concerns, please discuss them with your personal Plan Physician or with other Plan Providers who are treating you; they are committed to your satisfaction and want to help you with your concerns. If you want to change your personal Plan Physician, you may learn how to do so by calling the Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

## Filing claims

### ■ Claims for out-of-Plan emergency, Post-Stabilization, urgent care, and out-of-area dialysis care

To obtain payment for covered out-of-Plan emergency, Post-Stabilization, urgent care, and out-of-area dialysis care, (described in the "Benefits" section under "Emergency, Post-Stabilization, and urgent care" and "Out-of-area dialysis care"), ask the non-Plan Provider to submit a claim to us at the address on this page within 60 days or as soon as possible, but no later than 15 months after receiving care (or, up to 27 months according to Medicare rules, in some cases). If the provider refuses and bills you, send us the unpaid bill with a claim form.

You may request a claim form from the Claims Department of your local Member Services Department, or by calling our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.** Also, one of our representatives will be happy to assist you if you need help completing our claim form. Submit this claim form to us within 60 days or as soon as possible but no later than 15 months after receiving care (or up to 27 months according to Medicare rules in some cases). Fully complete and sign the claim form and attach itemized bills along with receipts if you have paid any or all of the bills. (Do not send any bills or claims to Medicare.) If you have copies of your medical records from the non-Plan Provider, attach them to your claim. Send your completed claim form with attached bills, receipts, copies of any medical records, and your Kaiser Permanente Medical Record Number to:

***Northern California Members:***

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

***Southern California Members:***

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

Northern California and Southern California Members may call toll free at **1-800-390-3510 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** for help with questions or concerns.

We will notify you of our decision within 60 days after we receive your claim. If we totally or partially deny your claim, we will notify you in writing of the reasons for denial and of your right to seek reconsideration. If you have not received a determination on your claim within 60 days after we receive your claim, you may assume the determination is negative and you may use the Medicare appeals procedure described on the following page under "Dispute resolution."

### ■ Claims for payment of other Services

Claims for payment of Services from non-Plan Providers (except covered care described under "Emergency, Post-Stabilization, and urgent care," or "Out-of-area dialysis care," in the "Benefits" section) that you believe should have been furnished or arranged for by Kaiser Permanente, should be submitted to your local Member Services Department. We will respond to your claim within 60 days. If we deny your claim, we will tell you the specific reasons for the denial. If you have not received a notice about our determination on your claim within 60 days after we receive it, you may assume the decision is negative and

you may request an appeal. Likewise, if you disagree with our decision, you may appeal our decision as described in the "Dispute resolution" section.

### ■ Requests for Services that you have not received

**Standard decision.** You may request that we provide health care Services that you have not received (except hospice care for Members with Medicare Parts A and B and qualifying Clinical Trials), but believe you are entitled to receive through Kaiser Permanente. These requests should be submitted in writing to your local Member Services Department. We will respond to your request within 14 days. If we deny your request, we will send you a notice that explains the reason for the denial and provides information about your appeal rights as described in "Dispute resolution."

**Expedited decision.** You may ask that we make an expedited decision on your request. Expedited review requests may be made orally or in writing. We will make an expedited decision within 72 hours if we find, or if your physician states, that your health or ability to regain maximum function could be seriously harmed by waiting 14 days for a standard decision. We may extend our decision for an additional 14 days beyond the 72-hour period if it is in your interest. Also, our decision may take longer if we have to wait for medical information from a non-Plan Provider, although we must make a decision within 72 hours of our receipt of the medical information.

You or your physician may request an expedited decision by calling us toll free at **1-888-987-7247** or by sending a written request to:

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

You may also fax your request to **1-888-987-2252,** or deliver your request in person to your local Member Services Department. Specifically state that you want an expedited decision, 72-hour decision, or that you believe that your health could be seriously harmed by waiting 14 days for a decision. If we deny your request, we will send you a notice that explains the reason for the denial and provides information about your appeal rights as described in the following "Dispute resolution" section.

## Dispute resolution

The following procedures for resolving disputes are discussed in detail on the following pages:

1. **Standard Medicare appeal procedure.** To appeal denied claims for payment or denied requests for Services when an expedited appeal is not required. (Does not apply to hospice care for Members with Medicare Parts A and B and qualifying Clinical Trials.)
2. **Expedited (72-hour) Medicare appeal procedure.** To appeal discontinuation of Services, or denied requests for Services when your health or ability to function could be seriously harmed by waiting 30 days for a standard Medicare appeal. (Does not apply to hospice care for Members with Medicare Parts A and B and qualifying Clinical Trials.)
3. **Immediate Quality Improvement Organization (QIO) review.** To appeal denial of continued coverage of your stay in a hospital when we have determined that hospitalization is no longer Medically Necessary.
4. **Member complaint and grievance procedures.** To report concerns about the quality of care or Services you receive or to seek resolution of any other issue if it is not subject to a Medicare appeals procedure.

5. **Quality Improvement Organization complaint procedure.** To report concerns about the quality of care you receive. You can also file a complaint with your local Quality Improvement Organization.
6. **Binding arbitration.** To resolve all other claims arising from your membership, unless otherwise indicated on the following pages.

## ■ A special note about hospice care

For Members entitled to Medicare Parts A and B, Medicare covers hospice care directly and it is not covered under this *DF/EOC*. Therefore, any disputes related to the coverage of hospice care for Members entitled to Medicare Parts A and B must be resolved directly with Medicare and not through any dispute resolution procedure discussed in this section.

## ■ Standard Medicare appeal procedure

This procedure applies to denied requests for Services and denied claims for payment of Services received from non-Plan Providers, including those related to Emergency Care, Post-Stabilization Care, urgent care, and out-of-area dialysis care (it does not apply to hospice care or qualifying Clinical Trials). For claims, we will process your reconsideration request within 60 days. For denied requests for Services that you believe are covered under this *DF/EOC,* we will process your reconsideration appeal within 30 days. If it is in your best interest, we may extend our decision for an additional 14 days beyond the 30-day period. **We will use this procedure to reconsider all claims and requests unless the expedited (72-hour) Medicare appeal procedure applies.**

If we deny your initial claim for payment or request for Services, we will tell you the specific reasons for the denial in a written denial notice. If you disagree with our decision, you have the right to request a reconsideration of our decision. Your reconsideration request must be filed in writing with us at the address shown on your denial notice, or with an office of the Social Security Administration, or if you are a qualified railroad Annuitant, with the Railroad Retirement Board. Even though you may file your appeal with the Social Security Administration or Railroad Retirement Board office, that office will transfer your appeal to us for processing.

You must submit your appeal within 60 days of the date on the denial notice, unless you show good cause for a delay past 60 days. You have the right to submit any new information to support your appeal in person or in writing.

If we do not rule fully in your favor, we will forward your appeal to the CMS's contractor, The Center for Health Dispute Resolution ("The Center"), for a decision. The Center will then make its own reconsideration decision and advise you of its decision, the reason for its decision, and your rights to a hearing before an administrative law judge.

If our decision is fully in your favor for the Services you requested, we will authorize or provide the Services to you as quickly as your health condition requires, but no later than 30 days from receipt of your appeal. If our decision is fully in your favor for a request for payment, we will pay for the Services no later than 60 days from receipt of your appeal. If The Center's decision is fully in your favor for a request for Services or payment, we will authorize, provide, or pay for the Services as quickly as your health condition requires but no later than 60 days from receipt of The Center's decision.

## ■ Expedited (72-hour) Medicare appeal procedure

This procedure applies to denied requests for Services that you believe we should provide, arrange, or continue (does not apply to hospice care or qualifying Clinical Trials).

This procedure does not apply to denied claims for payment. You may ask that we make an expedited decision on your reconsideration request. We will make an expedited decision within 72 hours if we find, or if your physician states, that your health or ability to regain maximum function could be seriously harmed by waiting 30 days for a standard Medicare appeal procedure decision. If it is in your best interest, we may extend the time frame to make our decision for an additional 14 calendar days beyond the 72-hour period. For example, you may need time to provide us with additional information, or we may need to have additional diagnostic tests completed. Also, our decision may take longer than 72 hours if we have to wait for medical information from a non-Plan Provider. However, we must make a decision within 72 hours of our receipt of the medical information.

You must submit your reconsideration request within 60 days of the date on the denial notice. You or your physician may request an expedited Medicare reconsideration request by calling toll free **1-888-987-7247,** or by writing to:

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

You may also fax your request to **1-888-987-2252,** or deliver your request in person to your local Member Services Department. Specifically state that you want an expedited reconsideration decision, 72-hour reconsideration decision, or that you believe that your health could be seriously harmed by waiting 30 days for a decision.

If we deny your request for an expedited Medicare reconsideration request, we will automatically review your request under the standard Medicare appeal procedure. You do not need to submit a separate reconsideration request. If you disagree with our decision not to expedite your reconsideration request, you may file a grievance as described in the "Member complaint and grievance procedures" section. If our decision under the standard or expedited Medicare appeal procedure is not fully in your favor, we will automatically forward your request for a reconsideration to CMS's contractor, The Center for Health Dispute Resolution ("The Center"), for an independent review. The Center will send you a letter with its decision within 72 hours of receipt of your case.

If our decision is fully in your favor for the Services you requested, we will authorize or provide the Service to you as quickly as your health condition requires but no later than 30 days from receipt of your reconsideration request. If The Center's decision is fully in your favor for the Services you requested, we will authorize, provide, or pay for those Services as quickly as your health condition requires, but no later than 60 days from receipt of The Center's decision.

**Support for your request.** You are not required to submit additional information to support your request for Services or payment for Services already received. We are responsible for gathering all necessary information, however, it may be helpful to you to include additional information to clarify or support your position. For example, you may want to include in your reconsideration request, information such as medical records or physician opinions in support of your reconsideration request. We will obtain medical records from Plan Providers on your behalf. If you have received out-of-Plan Services, you will need to contact the non-Plan Provider to obtain your medical records. You may need to send or fax a written request. Ask your physician to send or fax the records directly to us, if possible. We will provide an opportunity for you to provide additional information in person or in writing.

You may submit any new evidence to support your reconsideration request of denied requests for Services by mail, fax, phone, or in person at the numbers and/or addresses listed above for expedited Medicare appeals and standard Medicare appeals.

If you decide to appeal or request reconsideration and want help, you may have a doctor, friend, lawyer, or someone else help you. There are several groups that can help you. The following numbers are toll free:

Health Insurance Counseling
and Advocacy Program
**1-800-434-0222**
**(1-800-722-3140 TTY)**

Medicare Rights Center
**1-888-HMO-9050**

State Ombudsman
(for Skilled Nursing Facility issues)
**1-800-231-4024**

Area Agency on Aging
**1-800-510-2020**
(varies by county, check your telephone book) or call Eldercare Locator at **1-800-677-1116**

**If you disagree with The Center's decision.** If you disagree with The Center's decision about your standard or expedited reconsideration request, you may request a hearing before an administrative law judge by filing a written request at a Social Security office (or Railroad Retirement Board if a railroad Annuitant) or by writing to one of the following locations:

The Center for Health Dispute Resolution
1 Fishers Road, 2nd Floor
Pittsford, NY 14534-9597

***Northern California Members:***
Kaiser Foundation Health Plan, Inc.
Member Relations Department
P.O. Box 12916
Oakland, CA 94604-2916

***Southern California Members:***
Kaiser Foundation Health Plan, Inc.
Member Service Department
393 E. Walnut St.
Pasadena, CA 91188

This request must be filed within 60 days after the date of notice of The Center's adverse decision. This 60-day notice period may be extended for good cause by the administrative law judge. A hearing can be held only if the amount in controversy is $100 or more, as determined by the administrative law judge.

An adverse decision by the administrative law judge may be reviewed by the Departmental Appeals Board (DAB) of the Department of Health and Human Services, either by its own action or as the result of a request from you or from us. If the amount involved is $1,000 or more, either you or we may request that a decision made by the DAB be reviewed by a federal district court. The party requesting judicial review must notify the other parties involved. An initial, revised, or appeal determination made by us, The Center, an administrative law judge, or the DAB may be reopened (a) within 12 months, (b) within four years for just cause, or (c) at any time for clerical correction or in cases of fraud.

## ■ Immediate Quality Improvement Organization ("QIO") review

As a Kaiser Permanente Senior Advantage Member, you may request immediate Quality Improvement Organization ("QIO") review if you believe you are being asked to leave the hospital too soon and we deny coverage of your continued stay in a hospital because hospitalization is no longer Medically Necessary. A QIO is a group of doctors paid by the federal government to review the medical necessity, appropriateness, and quality of hospital treatment furnished to you. When we inform you that you are being discharged, we will provide a written "Notice of Discharge and Medicare Appeal Rights" that describes in detail the procedures available to you to request QIO review.

When you are admitted to any hospital, you will be provided with a document titled "An Important Message to Medicare Beneficiaries." That message will describe your rights while you are a hospital patient. Those rights include:

1. The right to receive all hospital care that is necessary for the proper diagnosis and treatment of your illness or injury and the right to have your discharge date determined solely by your medical need and not by any method of payment;
2. The right to be fully informed about decisions affecting the coverage and payment of your hospital stay and for any post-hospital Services; and
3. The right to request review by a QIO if we determine that your hospital stay is no longer Medically Necessary and you disagree.

**Requesting QIO review.** When you receive a "Notice of Discharge and Medicare Appeal Rights," and you believe that you are being asked to leave the hospital too soon, you may request immediate QIO review by phone or in writing. If you request QIO review by noon of the first business day after you receive a "Notice of Discharge and Medicare Appeal Rights," you will not be financially responsible for the cost of your hospitalization until the QIO makes a decision. By requesting QIO review, you may not use the standard Medicare appeal procedure or expedited Medicare appeal procedure described on page 113. The QIO will respond to your request for review of the "Notice of Discharge and Medicare Appeal Rights" by phone or in writing. The QIO will ask you your views about your case before making a decision.

If the QIO agrees with the "Notice of Discharge and Medicare Appeal Rights," you will be financially responsible for all costs of hospitalization beginning at noon of the day after you receive the QIO decision. If you do not agree with the QIO decision, you may request that the QIO immediately reconsider your case. The QIO may take up to three business days from receipt of your appeal to make a decision. The QIO will inform you in writing of the reconsideration decision. If the QIO continues to agree with the "Notice of Discharge and Medicare Appeal Rights," you will be financially responsible for the cost of your continued hospitalization beginning at noon of the day after you received the first QIO decision. If upon reconsideration, the QIO disagrees with the "Notice of Discharge and Medicare Appeal Rights," you will not be financially responsible for the cost of any additional hospital days approved by the QIO.

**Note:** If you do not request a QIO review, you will be financially responsible for the cost of your hospitalization beginning on the first day after receipt of the "Notice of Discharge and Medicare Appeal Rights." You may use the standard Medicare appeal procedure or expedited Medicare appeal procedure described on page 113, if you do not request a QIO review. However, you may be financially responsible for the cost of your hospitalization, beginning on the first day after receipt of the "Notice of Discharge and Medicare Appeal Rights," if the appeal is not in your favor.

## ■ Member complaint and grievance procedures

Our Member complaint and grievance procedures only apply if you have an issue that is not subject to a Medicare appeals procedure described on the previous pages.

We will make every attempt to resolve your issue promptly and we will send you our decision within 30 days of receiving a complaint or grievance (unless we notify you that we need additional time). In the case of a grievance and any subsequent grievance-appeal, we have a total of 30 days to respond. We will send you a letter confirming our receipt of your complaint, grievance, or grievance-appeal within five days.

**Complaints about quality of care or service.** If you have a complaint about the quality of care or Service, please contact a Member Service representative or a Patient Assistance coordinator at your local Kaiser Permanente facility or call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** to discuss your issue. Our representative will advise you about our resolution process and ensure the appropriate parties review your complaint.

**How to file a grievance.** For other issues, you may submit a grievance to a Member Service representative at any Plan Facility. Our representatives will be happy to help you if you need assistance writing the grievance. Also, we will notify you about your ability to present your case in person and to have someone represent you if applicable.

If we deny your grievance in whole or in part, we will let you know our reasons in a denial letter. You may request an appeal of our denial. To do so, please send your grievance-appeal to the Member Relations Department at the address specified in our grievance denial letter within six months. The appeal must set forth the reasons why you believe the decision was in error.

You will be informed in writing of our decision about your grievance-appeal. If we deny your appeal, in whole or in part, we will let you know our reasons and/or the provisions of this *DF/EOC* used in reaching that decision. You will also be given information about additional dispute resolution options that may apply.

## ■ Quality Improvement Organization complaint procedure

If you are concerned about the quality of care you have received, you may also file a complaint with the local Quality Improvement Organization by writing to California Medical Review, Inc., 60 Spear St., #400, San Francisco, CA 94105, or by calling toll free at **1-800-841-1602.** Quality Improvement Organizations are groups of doctors and health care professionals who monitor the quality of care provided to Medicare beneficiaries. The Quality Improvement Organization review process is designed to help stop any improper practices.

**Who may file.** The following persons may file a complaint, grievance, appeal or reconsideration request:

- You may file for yourself. If you want someone to file for you, provide us in writing with your name, your Medical Record Number, and a statement that appoints an individual as your authorized representative. An example of a statement is: "I [your name] appoint [name of representative] to act as my representative in requesting an appeal or reconsideration request from Kaiser Permanente (or the Centers for Medicare & Medicaid Services) regarding Kaiser Permanente's (denial) (discontinuation) of Services." You must sign and date the statement. Your representative must also sign and date this statement unless he/she is an attorney. Include this signed statement with your appeal or reconsideration request. (Authorization forms are also available from any Member Services Department.)
- You may generally file for a Dependent child. In some cases, you may be required to be appointed by your child as his or her authorized representative.

- A non-Plan Provider may file a standard reconsideration request of a denied claim if he/she completes a waiver of liability statement that says he/she will not bill you regardless of the outcome of the reconsideration request.
- A court-appointed guardian or an agent under a health care proxy to the extent provided under state law.

## ■ DMHC complaints

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. The department has a toll-free telephone number **1-888-HMO-2219** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone number **1-877-688-9891 (TDD)** to contact the department. The department's Internet Web site **(http://www.hmohelp.ca.gov)** has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at **1-800-464-4000** and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

## Binding arbitration

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

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

As referred to in this "Binding arbitration" section,

1. "Member Parties" include:
   a. A Member; or
   b. A Member's heir or personal representative; or
   c. Any person claiming that a duty to him or her arises from a Member's relationship to one or more Kaiser Permanente Parties.
2. "Kaiser Permanente Parties" include:
   a. Kaiser Foundation Health Plan, Inc. (Health Plan);
   b. Kaiser Foundation Hospitals (KFH);
   c. The Permanente Medical Group, Inc. (TPMG);
   d. Southern California Permanente Medical Group (SCPMG);

e. The Permanente Federation, LLC;

f. The Permanente Company, LLC;

g. Any KFH, TPMG, or SCPMG physician;

h. Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties; or

i. Any employee or agent of any of the foregoing.

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

4. "Respondent" refers to a Member Party or a Kaiser Permanente Party against whom a claim is asserted.

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.

**Arbitration Advisory Committee and independent administrator.** Health Plan appointed an Arbitration Advisory Committee to assist in the selection of an independent administrator to administer arbitrations under this "Binding arbitration" section, and to provide consultation to the independent administrator in administering these arbitrations. Upon the recommendation of the Arbitration Advisory Committee, Health Plan selected an independent administrator to perform these administrative services.

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

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

***Northern California Members:***

Kaiser Foundation Health Plan, Inc.
Legal Department
P.O. Box 12916
Oakland, CA 94604

***Southern California Members:***

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

Service on that Respondent shall be deemed completed when received.

All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

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

Any Claimant who claims extreme hardship may request that the Independent Administrator waive the filing fee and the Neutral Arbitrator's

fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling the Kaiser Permanente Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

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

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

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

**Payment of Arbitrator fees and expenses.** Health Plan will pay the fees and expenses of the Neutral Arbitrator under certain conditions as set forth in the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* (Rules of Procedure). In all other arbitrations, the fees and expenses of the Neutral Arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select Party Arbitrators, Claimants shall be responsible for paying the fees and expenses of their Party Arbitrator and Respondents shall be responsible for paying the fees and expenses of their Party Arbitrator.

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

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

**General provisions.** A claim shall be waived and forever barred if:

1. On the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondents served by the applicable statute of limitations; or
2. Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence; or
3. The arbitration hearing is not commenced within five years after the earlier of (i) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (ii) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim.

A claim may be dismissed on other grounds by the Neutral Arbitrator based on a showing of good cause. If a party fails to attend the

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

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

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

# Termination of Membership

The University is required to inform the Subscriber of the date your coverage terminates. If your membership terminates, all rights to benefits end at 12 a.m. on the termination date (for example, if your termination date is January 1, 2002, your last moment of coverage was 11:59 p.m., December 31, 2001.) In addition, a Dependent's membership ends at the same time the Subscriber's membership ends. You will be billed as a non-Member for any health care Services you receive after your membership terminates.

When your membership terminates under this section, Health Plan and Plan Providers have no further liability or responsibility under this *DF/EOC,* except (1) as provided under "Coverage for totally disabled persons" and "Payments after termination" in this "Termination of Membership" section, and (2) if you are receiving covered Services as an acute-care hospital inpatient on the termination date, we will continue to cover those hospital Services (but not physician Services or any other Services) until you are discharged.

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

## How you may terminate your membership

You should check with the University before you cancel your Senior Advantage membership to learn what other health benefit plans are available through the University, if any. You may terminate your Senior Advantage membership at any time.

## Disenrolling from Senior Advantage

If you request disenrollment during your group's open enrollment, your disenrollment effective date is determined by the date your written request is received by us and the date your group coverage ends. The effective date will not be earlier than the first day of the month following receipt of your written request, and no later than three months after receipt of your request.

If you request disenrollment at a time other than your group's open enrollment, your disenrollment effective date will be determined by the date your written request is received by us. If you terminate your membership on or after June 1, 2003, requests to disenroll will be effective the first day of the month after the month the disenrollment request is received. For example, if we receive your disenrollment request on July 15, your effective date will be August 1.

You may disenroll by sending a written notice to the address below. You may also disenroll at any Social Security office or Railroad Retirement Board office (if you are a railroad Annuitant) by completing a written request for disenrollment. However, although optional, we request that if you disenroll at a Social Security office or Railroad Retirement Board office, you also notify us.

***Northern California Members:***

Kaiser Permanente Senior Advantage
California Service Center
P.O. Box 232400
San Diego, CA 92193-2400
**1-800-731-4661** or
**1-800-464-4000**
**(1-800-777-1370 TTY),**
**7 a.m. to 7 p.m., seven days a week**

***Southern California Members:***

Kaiser Permanente Senior Advantage
California Service Center
P.O. Box 232407
San Diego, CA 92193-2407
**(626) 405-5188** or
**1-800-464-4000**
**(1-800-777-1370 TTY),**
**7 a.m. to 7 p.m., seven days a week**

**Note:** Until your membership terminates, you remain a Senior Advantage Member and must continue to receive your medical care from Health Plan, except as described under "Emergency, Post-Stabilization, and urgent care" in the "Benefits" section.

If you enroll in another Medicare+Choice plan, CMS will automatically terminate your Senior Advantage membership when your membership in the other organization becomes effective. If you disenroll and have Part B only, you will have to purchase Medicare Part A from the Social Security Administration to re-enroll in Senior Advantage in the future or to enroll in another Medicare+Choice plan.

## Termination due to loss of eligibility

If you met the eligibility requirements listed under the "Who is eligible" section on the first day of the month, but later in the month you no longer meet these eligibility requirements, your membership terminates on the last day of the month at 11:59 p.m., unless your group has an agreement with us to terminate at a time other than on the last day of the month. Please check with your group benefits administrator to confirm your termination date. In addition, your Dependents' membership ends at the same time the Subscriber's membership ends.

We must terminate your Senior Advantage membership on the last day of the month if you:

- Are temporarily absent from our Service Area for more than six months;
- Permanently move from our Service Area;
- Are no longer entitled to Medicare Parts A or B. Your Senior Advantage Membership termination will be effective the first day of the month following the month Medicare Parts A and B end.

**Note:** If you lose eligibility for Senior Advantage due to these circumstances, you may be eligible to transfer your membership to another Kaiser Permanente Plan offered by your group. Please contact your group's benefits administrator for information or refer to "Conversion of membership" in this "Termination of Membership" section.

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

1. **Subscriber and Dependents.** Group coverage ceases for a Subscriber and all enrolled Dependents when the Subscriber ceases to be eligible for group coverage.
2. **Dependents only.** When your family members no longer meet the eligibility requirements for coverage as Dependents, their right to receive benefits ends on the last day of the month in which the family member is no longer eligible.

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

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

   **Child:** Your child loses eligibility as a Dependent:

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

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

Dependents who lose eligibility as your Dependents may continue Kaiser Permanente membership with no break in coverage either through COBRA (please see the "Continuation of group coverage under federal or state law" section for details), or by converting to their own Individual Plan membership. Each Dependent will have to complete an application and submit it to a local Member Service office. Individual Plan applications may be submitted within 31 days after he or she no longer qualifies as a Dependent under this *DF/EOC*. Mail applications to:

Kaiser Foundation Health Plan, Inc.
P.O. Box 23059
San Diego, CA 92193-9922

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

## Termination of *Group Agreement*

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

### Coverage for totally disabled persons

If you became totally disabled after December 31, 1977, while you were a Member under the University's *Group Agreement* with us and while the Subscriber was employed by the University, and the University's *Group Agreement* with us terminates, coverage for your disabling condition will continue until any one of the following events occurs:

- 12 months have elapsed; or
- You are no longer disabled; or
- The University's *Group Agreement* with us is replaced by another group health plan without limitation as to the disabling condition.

Your coverage will be subject to the terms of this *DF/EOC,* including Copayments.

For Subscribers and adult Dependents, "totally disabled" means that, in the judgment of a Plan 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 Plan 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 child unable to substantially engage in any of the normal activities of children in good health of like age.

## Termination of contract with CMS

If our contract with CMS to offer Senior Advantage terminates, your membership will terminate on the same date. We will advise you of your health care options. Also, you may be eligible to transfer your membership to another Kaiser Permanente Plan offered by your group.

## Termination for cause

If you commit one of the following acts, we may terminate your membership by sending written notice to the Subscriber:

- You knowingly:
  1. Misrepresent membership status;
  2. Present an invalid prescription or physician order;
  3. Misuse (or let someone else misuse) a Member ID card; or
  4. Commit any other type of fraud in connection with your membership.
- You knowingly furnish incorrect or incomplete information to us or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits.

## Termination for nonpayment

You are entitled to health care coverage under this *DF/EOC* only for the period for which we receive the appropriate Dues from your group. If your group fails to pay us the appropriate Dues for your Family Unit, we will terminate the memberships of everyone in the Family Unit.

## Termination of a product or all products

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

## Payments after termination

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

- Refund any amounts we owe the University for Dues paid for the period after the termination date; and
- Pay you any amount due to you for claims for Services during your membership in accord with "Filing claims" under the "Getting assistance, filing claims, and dispute resolution" section. Any amounts you owe us will be deducted from any payment we make to you.

## Review of membership termination

If you believe that we terminated your membership because of your ill health or your need for care, you may file a grievance as described in the "Getting assistance, filing claims and dispute resolution" section or request a review of the termination by the California Department of Managed Health Care (please see "DMHC complaints" in the "Getting assistance, filing claims and dispute resolution" section).

## Continuation of group coverage under federal or state law

### ■ Federal law (COBRA)

You may be able to continue your coverage under this *DF/EOC* for a limited time when you would otherwise lose eligibility, if required by the federal COBRA law. COBRA applies to employees (and their covered family Dependents) of most employers with 20 or more employees. You must submit a COBRA election form to your group within the COBRA election period. Please ask your group's benefits administrator for the details about COBRA continuation coverage, such as how to elect coverage and how much you must pay.

If you choose not to apply for COBRA continuation coverage through your group, you may be able to convert to a nongroup Plan as described in "Conversion of membership" on pages 130 through 131. If you do enroll in COBRA, when you lose your COBRA eligibility, you may be able to continue coverage under state law as described in the following "State continuation coverage after COBRA coverage" section. Also, you may be able to convert to a nongroup Plan as described in "Conversion of membership" on pages 130 through 131.

## ■ State continuation coverage after COBRA coverage

If you lose eligibility for COBRA coverage because you exhaust the length of time allowed for COBRA coverage, you may be eligible to continue your group coverage under state law (state continuation coverage) if required by Section 1373.621 of the California Health and Safety Code. To continue your group coverage under state law, you must call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** to request enrollment within 30 days before the date COBRA continuation coverage is scheduled to end and pay applicable Dues to us. In addition, you must meet one of the following requirements:

- You are a Subscriber who was 60 years of age or older and were employed by your group for at least five years before the date employment with your group terminated;
- You are the Spouse of a Subscriber who dies, divorces, legally separates, or becomes entitled to Medicare; or
- You are a former Spouse of a Subscriber.

**Termination of state continuation coverage.** Coverage continues only upon payment of applicable monthly Dues to us at the time we specify, and terminates on the earliest of:

- The date your group's *Agreement* with us terminates;
- 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 coverage was scheduled to end, if you are a Subscriber's Spouse or former Spouse; or
- When you fail to make payments to us when due.

If you do not elect state continuation coverage, you may be able to convert to a nongroup Plan as described in "Conversion of membership" on pages 130 through 131.

# Converting group coverage under federal or state law

## ■ Optional continuation of coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, enrolled persons who would lose coverage under the Kaiser Permanente Senior Advantage medical Plan due to certain "qualifying events" are entitled to elect, without having to submit evidence of good health, continued coverage at their own expense. Continued coverage shall be the same as for active eligible employees and their eligible Dependents under the University group plan. If coverage is modified for active eligible employees and their Dependents, it shall be modified in the same manner for persons with continued coverage (qualified beneficiaries) and an appropriate adjustment in premiums may be made.

## ■ Right to continue benefits

A right under this part is subject to the rest of these provisions:

You have the right to continue benefits under the Plan for yourself and any enrolled Dependents if your coverage would have ended because of the following qualifying events:

1. Because your employment ended for a reason other than gross misconduct; or

2. Because your work hours were reduced (including approved leave without pay or layoff).

Each of your eligible Dependents has the right to continue benefits under the Plan under the following circumstances:

In the case of your eligible Dependent Spouse, your Spouse may continue coverage for himself or herself and any enrolled Dependent children if your Spouse's coverage would have ended because of any of the following qualifying events:

1. Because your employment ended for a reason other than gross misconduct; or
2. Because your work hours were reduced (including approved leave without pay or layoff); or
3. At your death; or
4. Because you became entitled to Medicare benefits; or
5. When your Spouse ceased to be an eligible Dependent as a result of a divorce, legal separation, or annulment.

If coverage ends under (5) immediately above, please see the following **"Notice."**

In the case of your eligible Dependent child, your child may continue coverage for himself or herself if your child's coverage would have ended because of any of the following qualifying events:

1. Because your employment ended for a reason other than gross misconduct; or
2. Because your work hours were reduced (including approved leave without pay or layoff); or
3. At your death; or
4. Because you became entitled to Medicare benefits; or
5. Because of your divorce, legal separation, or annulment; or
6. When your eligible Dependent child ceased to be an eligible Dependent under the rules of the Plan.

If coverage for an eligible Dependent ends due to an event shown in (5) or (6) immediately above, please see **"Notice"** below.

For qualifying event (1) or (2), if you become entitled to Medicare, due to age, within 18 months before the qualifying event, your eligible Dependent Spouse or your eligible Dependent child may continue COBRA coverage for up to 36 months counted from the date you became entitled to Medicare.

If a second qualifying event occurs to a qualified beneficiary who already has continuation coverage because your employment has ended or work hours were reduced, the qualified beneficiary's coverage may be continued up to a maximum of 36 months from the date of the first qualifying event.

**Notice:** If your coverage for an eligible Dependent ends due to your divorce, legal separation, or annulment, or if your eligible Dependent ceased to be an eligible Dependent under the rules of the Plan, you or your eligible Dependent must give written notice of the event to the employer at the University of California Customer Service Center within sixty (60) days of the event or eligibility to elect continuation coverage will be lost.

## ■ Continuation

Once aware of a qualifying event, the employer will give a written election notice of the right to continue the coverage to you (or to the qualified beneficiary in the event of your death). Such notice will state the amount of the premium required for the continued coverage. If a person wants to continue the coverage, the election notice must be completed and returned to the following address within sixty (60) days of the later of:

1. The date of the qualifying event; or
2. The date the qualified beneficiary received notice informing the person of the right to continue.

   Kaiser Foundation Health Plan, Inc.
   P.O. Box 23127
   San Diego, CA 92193-3127
   Attention: COBRA
   **1-888-236-4490**

Benefits of the continuation Plan are identical to this group medical Plan, and the cost is explained on page 130 under "Cost of continuation coverage."

The continued coverage period runs concurrently with any other University continuation provision (such as during leave without pay) except continuation under the Family and Medical Leave Act (FMLA). Coverage will be continued from the date it would have ended until the first of these events occurs:

1. With respect to yourself and any qualified beneficiaries, the day 18 months from the earlier of the date:
   a. Your employment ends for a reason other than gross misconduct, or
   b. Your work hours are reduced. But coverage may continue for all qualified beneficiaries for up to 11 additional months while the qualified beneficiary is determined to be disabled under Title II or XVI of the United States Social Security Act if:
      i. The disability was determined to exist at the time, or during the first sixty (60) days, of the 18 months of COBRA coverage; and
      ii. The person gives Health Plan written notice of the disability within sixty (60) days after the determination of disability is made and within 18 months after the date employment ended or work hours were reduced.

   Kaiser Permanente must be notified if there is a final determination under the United States Social Security Act that the person is no longer disabled. The notice must be provided within thirty (30) days after the final determination. The coverage will end on the first of the month that starts more than thirty (30) days after the determination.
2. With respect to your qualified beneficiaries (other than yourself), the day 36 months from the earliest of the date:
   a. Of your death; or
   b. Of your entitlement to Medicare benefits; or
   c. Of your divorce, annulment, or legal separation from your Spouse; or
   d. Your Dependent child ceases to be an eligible Dependent under the rules of the Plan.

   The 36 months will be counted from the date of the earliest qualifying event.
3. With respect to any qualified beneficiary:
   a. If the person fails to make any premium payment required for the continued coverage, the end of the period for which the person has made required payments.
   b. The day the person becomes covered (after the day the person made the election for continuation of coverage) under any other group health plan, on an insured or uninsured basis. This item 3(b) by itself will not prevent coverage from being continued until the end of any period for which preexisting conditions are excluded or benefits for them are limited under the other health plan.
   c. The day the person becomes entitled to Medicare benefits.
   d. The day the employer no longer provides group health coverage to any of its employees.

## ■ California continuation coverage

Employees entitled to COBRA continuation coverage due to employment termination on or after January 1, 1996, are entitled to extend medical coverage for themselves and their Spouses after their initial 18-month COBRA period ends, provided the employee was at least age 60 on the date employment ended, had worked for the University for at least five continuous years immediately prior to termination, and was eligible for and elected COBRA continuation medical plan coverage in connection with the termination of employment. The former Spouse of the above former employee is entitled to California continuation coverage, provided the former Spouse continued coverage under COBRA as a qualified beneficiary. This continuation does not apply to children of a former employee. The continuation will end on the earlier of:

1. The date the individual turns 65;
2. The date the University no longer maintains the group plan, including any replacement plan;
3. The date the individual is covered by a group medical plan not maintained by the University;
4. The date the individual becomes entitled to Medicare; or
5. With respect to the Spouse or former Spouse only, the date five years from the date COBRA ends for the Spouse or former Spouse.

If the employee's coverage terminates, the Spouse may continue coverage until one of the terminating events applies to the Spouse. Kaiser Permanente will notify eligible COBRA-qualified beneficiaries before the end of the maximum 18-month COBRA continuation period.

If an eligible individual wishes to continue the coverage, he or she must apply, in writing, to the medical carrier no later than 30 days before the end of the COBRA continuation period.

## ■ Cost of continuation coverage

The cost of the continuation coverage will:

1. Include any portion previously paid by the employer and shall not be more than 102 percent of the applicable group rate during the period of basic COBRA coverage; or
2. Not be more than 150 percent anytime during the 11-month disability extension period (for example, during the 19th through the 29th month); or
3. Not be more than 213 percent during the extension period allowed by California continuation coverage.

For information on open enrollment actions for which a qualified beneficiary may be eligible and/or any applicable Plan modifications and premium adjustment, contact the University of the California Human Resources and Benefits at **1-800-888-8267,** extension 7-0651, during the month of November.

**Note:** When your continuation of coverage ends, you may be eligible to convert your coverage to Individual Plan membership.

# Conversion of membership

If you are no longer entitled to Medicare, as described under the "Who is eligible" section, or if our contract with CMS terminates, you may be eligible to transfer your membership to another Kaiser Permanente Plan offered by the University. Please contact the University for details.

If you no longer qualify because the University's *Group Agreement* with us terminates for any reason, or if you no longer qualify as a Member under the eligibility requirements

described in the "Who is eligible" section (this includes termination of continuing group coverage under COBRA) you may be eligible to continue coverage under a Kaiser Permanente Senior Advantage Individual Plan agreement. Dues and benefits will vary from this group Plan. Information about our Individual Plan will be sent to you upon termination of your group coverage. To continue coverage, apply to your local Kaiser Permanente Health Plan office within 31 days after you lose eligibility. No statement of health is required. Your Individual Plan coverage will begin at the time your group coverage ends.

If you do not convert, your coverage will end at the end of the last month for which you are eligible for group coverage and for which we receive payment.

If you wish to discontinue coverage, follow the steps set forth under "How you may terminate your membership" in this "Termination of Membership" section. Call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** for more information.

**Note:** As long as you continue to qualify for group eligibility, you may not convert to an Individual Plan. In addition, you are not eligible to convert if your membership ends because our *Group Agreement* with your group terminates, or we terminate your coverage under the "Termination for cause" section.

## Certificates of Creditable Coverage

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

SECTION THREE

# General Information for All Members

■

*Kaiser Permanente*

*Combined Disclosure Form and*

*Evidence of Coverage*

*for the*

*University of California*

*Effective January 1, 2003*

**Member Service Call Center**
**1-800-464-4000**
**7 a.m. to 7 p.m., seven days a week**

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

**www.kaiserpermanente.org**

SECTION THREE

# General Information for All Members

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# Table of Contents

# Miscellaneous Provisions

## Administration of *Agreement*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the *Group Agreement* and this *DF/EOC.*

## Advance directives

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

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

For additional information about advance directives, including how to obtain forms and instructions, contact your local Member Services Department.

## *Agreement* binding on Members

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

## Amendment of *Agreement*

The University's *Group Agreement* with us will change periodically. If the changes affect this *DF/EOC,* revised materials will be made available to you.

## Applications and statements

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

## Assignment

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

## Attorney fees and expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

## Governing law

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

## Group and Members not Health Plan's agents

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

## Health Insurance Counseling and Advocacy Program (HICAP)

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

## Privacy practices

Health Plan and Plan Providers will protect the privacy of your protected health information (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.

Plan Providers and employees are required to protect the privacy of your PHI and receive training on how to do so. All providers with whom we contract also are required to protect the privacy 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. In addition, we are sometimes required by law to give PHI to government agencies or in judicial actions. 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).

We will ask for an authorization in writing from you or your personal representative when we wish to use or disclose your PHI. Executing an authorization is at your discretion. You do not have to authorize use or disclosure of your PHI if you choose not to. A refusal to execute an authorization will not affect your right to receive covered Services.

**A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.**

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* explains our privacy practices in detail. To request a copy, please call our Member Service Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.** You can also find the notice at your local Plan Facility or on our Internet Web site at *www.kaiserpermanente.org*.

## Member rights and responsibilities

As a Member, it is important to know your rights and responsibilities, which are discussed in *Your Guidebook to Kaiser Permanente Services*. To obtain a current copy of *Your Guidebook,* please call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week.**

## Named fiduciary

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

## No waiver

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

## Nondiscrimination

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

## Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call our Member Service Call Center toll free at **1-800-464-4000 (1-800-777-1370 TTY), 7 a.m. to 7 p.m., seven days a week** as soon as possible to provide their new address. If a Member does not reside with the Subscriber, he or she should contact our Member Service Call Center to discuss alternate delivery options.

## Overpayment recovery

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

# Definitions

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

**Affiliated Providers:** Any provider who has contracted to provide Services to those Members residing and seeking care in Coachella Valley or western Ventura County. These providers include Affiliated Hospitals, Affiliated Physicians, Affiliated Medical Groups, Affiliated Plan Medical Offices, and Affiliated Pharmacies.

**Charges:** Either (1) for Services for which the provider was compensated on a capitation basis, the Charges in the provider's schedule of Charges for Services provided to the general public (or, for Members, the provider's schedule of Charges for Services provided to Members, if different), (2) for items covered under "Drugs, supplies, and supplements" and obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item, or (3) for all other Services, the payments that Kaiser Permanente made for the Services.

**CMS:** Centers for Medicare & Medicaid Services (formerly known as the Health Care Financing Administration) is the federal agency that administers the Medicare program.

**Clinical Trial:** A research study that tests how well new medical treatments or other interventions work in people. Each study is designed to test new methods of screening, prevention, diagnosis, or treatment of a disease.

**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.

**Conversion Plan:** A basic medical care program which allows Members to continue uninterrupted coverage with benefits that may differ from those offered through their employer.

**Copayment:** The amount that you must pay when you receive a covered Service as listed in the "Copayments" section. For certain Services, we will charge either the Copayment or 50 percent of Charges, whichever is less. For items described in the "Benefits" section under the heading "Outpatient drugs, supplies, and supplements," we will charge either the Copayment listed in the "Copayments" section or the amount we would charge a Member for the item if a Member's benefit plan did not cover the item, whichever is less.

**Dependent:** A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent in the "Who is eligible" section of the applicable *DF/EOC.*

**Dues:** Periodic membership charges paid by group.

**Emergency Care:** Emergency Care is Medically Necessary ambulance Services and evaluation by a physician (or other appropriate personnel under the supervision of a physician to the extent provided by law) to determine if an Emergency Medical Condition exists. If one exists, Emergency Care is also the Medically Necessary care, treatment, and surgery required to stabilize your Emergency Medical Condition (make you Clinically Stable) within the capabilities of the facility.

**Emergency Medical Condition:** An Emergency Medical Condition is a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in any of the following:

- Your health is placed in serious jeopardy;
- Serious impairment in your bodily functions; or
- Serious dysfunction of any bodily organ or part.

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

**Health Plan:** Kaiser Foundation Health Plan, Inc., a California nonprofit corporation.

**Kaiser Permanente:** Health Plan, Kaiser Foundation Hospitals, and the Medical Groups.

**Medical Group:** The Permanente Medical Group, Inc., in the Northern California Region, or the Southern California Permanente Medical Group in the Southern California Region, a for-profit professional organization.

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

**Medicare:** A federal health insurance program for people 65 and older, certain disabled people, and people with end-stage renal disease (ESRD).

**Member:** A person who is eligible and enrolled under this *DF/EOC,* and for whom we have received applicable Dues. This *DF/EOC* sometimes refers to Members as "you" or "your."

**Out-of-Area Urgent Care:** An urgent care need requires prompt medical attention, but is not an Emergency Medical Condition. Out-of-Area Urgent Care is Medically Necessary Services you receive from a non-Plan Provider for an unforeseen illness or injury if all of the following is true:

- You are temporarily outside of our Service Area.
- The Services are necessary to prevent serious deterioration of your health.
- Treatment cannot be delayed until you return to our Service Area.

**Plan:** Kaiser Permanente.

**Plan Facility:** A Plan Medical Office or Plan Hospital. Please refer to *Your Guidebook to Kaiser Permanente Services* for the types of Services available from each Plan Facility.

**Plan Hospital:** Any hospital in our Service Area where you receive hospital care pursuant to arrangements made by a Plan Physician. Please refer to *Your Guidebook to Kaiser Permanente Services* for the types of Services available from each Plan Hospital.

**Plan Medical Office:** Any outpatient treatment facility staffed by Plan Physicians. Please refer to *Your Guidebook to Kaiser Permanente Services* for the types of Services available from each Plan Medical Office.

**Plan Pharmacy:** Any pharmacy located at a Plan Facility or any other pharmacy that we designate.

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

**Plan Provider:** A Plan Hospital, Plan Physician, or other health care provider that contracts to provide Services to Members (but not including providers who contract only to provide referral Services).

**Post-Stabilization Care:** Post-Stabilization Care is the Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable. Post-Stabilization Care can be provided while you are still in a hospital Emergency Department, after you have been admitted to a hospital, or in another setting.

**Region:** A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. For information about Region locations, please call our Member Service Call Center.

**Services:** Health care services or items.

**Skilled Nursing Facility:** A facility that is licensed by the state of California, and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care.

**Spouse:** Your legal husband or wife.

**Subscriber:** A Member who is eligible for membership on his or her own behalf through a relationship to group and not by virtue of dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see the "Who is eligible" section of the applicable *DF/EOC*).

# Service Area

## Northern California Service Area—Kaiser Permanente Traditional Plan

The following counties are entirely within our Northern California Traditional Plan Service Area: Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, San Mateo, Solano, and Stanislaus. Portions of the following counties, as indicated by the ZIP codes below, are also within this Service Area:

**Amador:** 95640, 95669

**El Dorado:** 95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, 95762

**Fresno:** 93242, 93602, 93606-07, 93609, 93611-13, 93616, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-12, 93714-18, 93720-22, 93724-29, 93740-41, 93744-45, 93747, 93750, 93755, 93760-62, 93764-65, 93771-80, 93784, 93786, 93790-94, 93844, 93888

**Kings:** 93230, 93232

**Madera:** 93601, 93604, 93614, 93637-39, 93643-45, 93653, 93669

**Mariposa:** 93623

**Napa:** 94503, 94508, 94515, 94558-59, 94562, 94567*, 94573-74, 94576, 94581, 94599

**Placer:** 95602-04, 95648, 95650, 95658, 95661, 95663, 95677-78, 95681, 95703, 95722, 95736, 95746-47, 95765

**Santa Clara:** 94022-24, 94035, 94039-43, 94085-90, 94301-02, 94304-06, 94309-10, 95002, 95008-09, 95011, 95013-15, 95020**-21, 95026, 95030-33, 95035-38, 95042, 95044, 95046, 95050-56, 95070-71, 95101-03, 95106, 95108-42, 95148, 95150-61, 95164, 95170-73, 95190-94, 95196

**Sonoma:** 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:** 95659, 95668, 95674, 95676

**Tulare:** 93618, 93666, 93673

**Yolo:** 95605, 95607, 95612, 95616-18, 95645, 95691, 95694-95, 95697-98, 95776, 95798-99

**Yuba:** 95692, 95903, 95961

* The Knoxville community, which lies within Pope Valley ZIP code 94567, is not in the Service Area.

** The Bells Station community, which lies within Gilroy ZIP code 95020, is not in the Service Area.

## Southern California Service Area—Kaiser Permanente Traditional Plan

The following counties are entirely within our Southern California Traditional Plan Service Area: Los Angeles (except ZIP code 90704) and Orange. Portions of the following counties, as indicated by the ZIP codes below, are also within this Service Area:

**Imperial:** 92275*

**Kern:** 93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93250-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-13, 93380-90, 93501-02, 93504-05, 93518-19, 93531, 93560-61, 93581

**Riverside:** 91752, 92201-03*, 92210-11*, 92220, 92223, 92230*, 92234-36*, 92240-41*, 92253-55*, 92258*, 92260-64*, 92270*, 92274*, 92276*, 92282*, 92292*, 92320, 92501-09, 92513-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92595-96, 92599, 92860, 92877-83

**San Bernardino:** 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758, 91761-64, 91784-86, 91798, 92252*, 92256*, 92268*, 92277*-78*, 92284-86*, 92305, 92307-08, 92313-18, 92321-22, 92324-26, 92329, 92333-37, 92339-41, 92345-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-94, 92397, 92399, 92401-08, 92410-15, 92418, 92420, 92423-24, 92427

**San Diego:** 91901-03, 91908-17, 91921, 91931-33, 91935, 91941-47, 91950-51, 91962-63, 91976-80, 91990, 92007-09, 92014, 92018-27, 92029-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-58, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92082-85, 92090-93, 92096, 92101-24, 92126-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-79, 92182, 92184, 92186-87, 92190-99

**Tulare:** 93261

**Ventura:** 91319-20, 91358-63, 91377, 93001-07*, 93009*, 93010-12, 93015-16, 93020-21, 93022*, 93030-36*, 93040, 93041-44*, 93060-61*, 93062-66, 93093-94, 93099

* Subscribers residing in Coachella Valley and western Ventura County ZIP codes are required to select a primary care Plan Physician (Affiliated Physician) for themselves and each covered Dependent. Please refer to "Your primary care Plan Physician" under "How to Obtain Services" in "Section One, Traditional Plan" for details.

## Northern California Group Plan Service Area—Kaiser Permanente Senior Advantage

The following counties are entirely within our Senior Advantage Northern California Group Plan Service Area: Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, San Mateo, Solano, and Stanislaus. Portions of the following counties, as indicated by the ZIP codes below, are also within this Service Area:

**Amador:** 95640, 95669

**El Dorado:** 95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, 95762

**Fresno:** 93242, 93602, 93606-07, 93609, 93611-13, 93616, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-12, 93714-18, 93720-22, 93724-29, 93740-41, 93744-45, 93747, 93750, 93755, 93760-62, 93764-65, 93771-80, 93784, 93786, 93790-94, 93844, 93888

**Kings:** 93230, 93232

**Madera:** 93601, 93604, 93614, 93637-39, 93643-45, 93653, 93669

**Mariposa:** 93623

**Napa:** 94503, 94508, 94515, 94558-59, 94562, 94567*, 94573-74, 94576, 94581, 94599

**Placer:** 95602-04, 95648, 95650, 95658, 95661, 95663, 95677-78, 95681, 95703, 95722, 95736, 95746-47, 95765

**Santa Clara:** 94022-24, 94035, 94039-43, 94085-90, 94301-02, 94304-06, 94309-10, 95002, 95008-09, 95011, 95013-15, 95020**-21, 95026, 95030-33, 95035-38, 95042, 95044, 95046, 95050-56, 95070-71, 95101-03, 95106, 95108-42, 95148, 95150-61, 95164, 95170-73, 95190-94, 95196

**Sonoma:** 94922-23, 94927-28, 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:** 95659, 95668, 95674, 95676

**Tulare:** 93618, 93666, 93673

**Yolo:** 95605, 95607, 95612, 95616-18, 95645, 95691, 95694-95, 95697-98, 95776, 95798-99

**Yuba:** 95692, 95903, 95961

* The Knoxville community, which lies within Pope Valley ZIP code 94567, is not in the Service Area.

** The Bells Station community, which lies within Gilroy ZIP code 95020, is not in the Service Area.

**Note:** Only Members who were enrolled in Senior Advantage on December 31, 1998, without Medicare Part A, may continue enrollment without Medicare Part A entitlement.

## Southern California Group Plan Service Area—Kaiser Permanente Senior Advantage

The following counties are entirely within our Senior Advantage Southern California Group Plan Service Area: Los Angeles and Orange (except ZIP codes 90704 and 93584). Portions of the following counties, as indicated by the ZIP codes below, are also within this Service Area:

**Kern:** 93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93250-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-13, 93380-90, 93501-02, 93504-05, 93518, 93531, 93560-61, 93581

**Riverside:** 91752, 92201-03*, 92210-11*, 92220, 92223, 92230*, 92234-36*, 92240-41*, 92253*, 92255*, 92258*, 92260-64*, 92270*, 92276*, 92282*, 92292*, 92320, 92501-09, 92513-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92595-96, 92860, 92877-83

**San Bernardino:** 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758, 91761-64, 91784-86, 91798, 92305, 92307-08, 92313-18, 92321-22, 92324-26, 92329, 92333-37, 92339-41, 92345-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-94, 92397, 92399, 92401-08, 92410-15, 92418, 92420, 92423-24, 92427

**San Diego:** 91901-03, 91908-17, 91921, 91931-33, 91935, 91941-47, 91950-51, 91962-63, 91976-80, 91990, 92007-09, 92014, 92018-27, 92029-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-58, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92082-85, 92090-93, 92096, 92101-24, 92126-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-79, 92182, 92184, 92186-87, 92190-99

**Tulare:** 93261

**Ventura:** 91319-20, 91358-63, 91377, 93001-07*, 93009*, 93010-12, 93015-16, 93020-21, 93022*, 93030-36*, 93040, 93041-44*, 93060-61*, 93062-66, 93093-94, 93099

* Subscribers residing in Coachella Valley and western Ventura County ZIP codes are required to select a primary care Plan Physician (Affiliated Physician) for themselves and each covered Dependent. Please refer to "Your primary care Plan Physician" under "How to Obtain Services" in "Section Two, Senior Advantage Plan" for details.

**Note:** Only Members who were enrolled in Senior Advantage on December 31, 1998, without Medicare Part A, may continue enrollment without Medicare Part A entitlement.

# Injuries or Illnesses Caused or Alleged to Be Caused by Third Parties

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

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

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

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

***Northern California Members:***

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

***Southern California Members:***

Kaiser Permanente
Special Recovery Unit-8553
Parsons East, 2nd Floor
P.O. Box 7017
Pasadena, CA 91109-9977

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay us directly. You must not take any action prejudicial to our rights.

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

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

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers ordinarily charge to the general public ("General Fees"). However, these contracts may allow the providers to assert any independent lien rights they may have to recover their General Fees from a judgment or settlement that you receive from or on behalf of a third party. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

# Plan Administration

By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in the source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this booklet is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this booklet and/or the *Group Medical and Hospital Service Agreement*. What is written in this booklet does not constitute a guarantee of plan coverage or benefits—particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

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

## Sponsorship and administration of the Plan

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

University of California
Human Resources and Benefits
300 Lakeside Drive, 5th Floor
Oakland, CA 94612-3557
**1-800-888-8267**

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

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

***Northern California Members:***
Kaiser Foundation Health Plan, Inc.
Claims Administration Department
P.O. Box 12923
Oakland, CA 94604-2923
**(510) 987-1400** or **1-800-464-4000**

***Southern California Members:***
Kaiser Foundation Health Plan, Inc.
Claims Administration Department
P.O. Box 7102
Pasadena, CA 91109-9880
**1-800-390-3510**

## Group contract number for Northern California Members

The group contract number for University of California, Northern California, is Group 7.

## Group contract numbers for Southern California Members

The group contract numbers for University of California, Southern California, are Groups 102601, 102602, 102603, 102604, 102605, 102607, 102608, 102610, 102611, 102624, and 102625.

## Type of Plan

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

## Plan year

The Plan year is January 1 through December 31.

## Continuation of the Plan

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

## Financial arrangements

The benefits under the Plan are provided or arranged for by Kaiser Foundation Health Plan, Inc., a federally qualified health maintenance organization providing health care under a *Group Agreement*.

## Agent for serving of legal process

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

***Northern California Members:***

Kaiser Foundation Health Plan, Inc.
Legal Department
P.O. Box 12916
Oakland, CA 94604

***Southern California Members:***

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

## Your rights under the Plan

As a participant in a University of California medical plan, you are entitled to certain rights and protections.

All Plan participants shall be entitled to:

- Examine, without charge, at the Plan administrator's office, and other specified sites, all Plan documents, including the *Group Agreement,* at a time and location mutually convenient to the participant and the Plan administrator.
- Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan administrator.

## Claims under the Plan

To file a claim or to appeal a denied claim, refer to the applicable "Getting Assistance, Filing Claims, and Dispute Resolution" section of this *DF/EOC.*

## Nondiscrimination statement

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

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

Director Mattie L. Williams
University of California
Office of the President
300 Lakeside Drive
Oakland, CA 94612

and for faculty to:

Executive Director Sheila O'Rourke
University of California
Office of the President
1111 Franklin St.
Oakland, CA 94607

# Index

# Addendum

**Please note: The following Reductions were inadvertently left out of "Section Two, Senior Advantage Plan," page 110.**

## Additional Reductions

- **Employer responsibility.** For any Services that the law requires an employer to provide, we will not pay the employer, and if 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 if we cover any such Services we may recover the value of the Services from the government agency.
- **Workers' compensation or employer's liability benefits.** You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as a "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any such Services from the following sources:

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

Member Service Call Center
1-800-464-4000

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

www.kaiserpermanente.org

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