2011 KAISER PERMANENTE HIPAA PLANS

NORTHERN CALIFORNIA

KAISER PERMANENTE®

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Note:

Help in your language

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

Ayuda en su propio idioma

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

語言翻譯協助

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

CHOOSING THE RIGHT PLAN

Thank you for your interest in the Kaiser Permanente HIPAA plans. Under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), you are guaranteed coverage in a Kaiser Permanente HIPAA plan without medical screening if you meet certain specific eligibility requirements **and** provide proof of prior creditable coverage.

There are two plan options from which you can choose. The Kaiser Permanente HIPAA Copayment 25 plan offers lower copayments at the time of service and the Kaiser Permanente HIPAA Deductible 30/1500 plan offers a lower monthly rate.

Two HIPAA plans

Our two HIPAA plans offer subscriber-only coverage. Families may still apply to enroll in our plans—but each family member must fill out a separate application and will be enrolled in his or her own plan.

Family members do not have to apply to enroll in the same plan. This allows you to select different plans for different family members, depending on their needs.

For example, you may select the extra coverage offered by the HIPAA Copayment 25 plan for young children. But perhaps you might choose the less expensive HIPAA Deductible 30/1500 plan for yourself. The choice is yours.

We encourage you to apply to enroll all your family members in a HIPAA plan to avoid any lapse in coverage. Once you have coverage established, you or your family members may submit a medical review form and apply for one of our Kaiser Permanente for Individuals and Families (KPIF) plans, which offer a broader selection of benefits.

Factors affecting your rate

We are committed to providing you with continued coverage at competitive rates for all the quality health care benefits available to you. The monthly rate you pay for your coverage depends on your plan, your age on January 1, 2011, and where you live. If you change plans or move to a new residence and change ZIP codes, your monthly rate will change on the month following your change.

Finding your rate(s):

- Locate your ZIP code in the listing on page 5 to determine your rate area.
- Turn to the rate chart on page 4 and find your rate area and plan in the top row.
- Find your age in the chart.
- Your rate will appear in the box where the column and row intersect.

Repeat these steps for each family member applying for coverage. Then add the rates for all family members to determine your combined monthly premium.

Please note: If your ZIP code does not appear on page 5, contact our Member Service Call Center at **1-800-464-4000** for information on other rate areas.

If you choose to apply and are accepted for the Kaiser Permanente HIPAA Copayment 25 plan, you may change at a later date to the HIPAA Deductible 30/1500 plan. However, if you choose to apply and are accepted for the HIPAA 30/1500 plan, you will not be able to change to the HIPAA Copayment 25 plan after 30 days following your effective date.

If you have any questions, please call our Member Service Call Center at **1-800-464-4000** from 7 a.m. to 7 p.m., weekdays, and 7 a.m. to 3 p.m., weekends (except holidays), and talk to one of our Member Service representatives.

We look forward to providing you with high-quality health care for many years to come.

BENEFIT HIGHLIGHTS

Health plan benefits and coverage comparison chart for the Kaiser Permanente HIPAA Copayment 25 and the HIPAA Deductible 30/1500 plans

To assist you in choosing your health coverage, we've provided an overview of benefits and copayments for both the HIPAA Copayment 25 and the HIPAA Deductible 30/1500 plans. This overview is intended to help you compare coverage benefits and is a summary only.

Please refer to the *Membership Agreements* for a detailed description of copayments and coinsurance.

	COPAYMENT 25	DEDUCTIBLE 30/1500
Features		
Annual deductible	None	$1,500
Annual out-of-pocket maximum	$2,500	$3,500
Benefits	Services not subject to deductible unless otherwise indicated	
Preventive care		
Immunizations	No charge	
Routine physical exam	No charge	
Well-child visit (0–23 months)	No charge	
Well-woman visit	No charge	
Mammogram (screening)	No charge	
Outpatient services (per visit or procedure)		
Primary care/Specialty office visit	$25 copay	$30 copay
Most X-rays and lab tests	$10 copay	$10 copay (after deductible)
MRI, CT, and PET	$50 copay	$50 copay (after deductible)
Outpatient surgery	$100 copay	$250 copay (after deductible)
Inpatient hospital care		
Room and board, surgery, anesthesia, X-rays, lab tests, and medication	$200 copay per day	$500 copay per day (after deductible)
Maternity	Coverage varies. Please consult the plan's *Membership Agreement.*	
Maternity care	Covered	Covered (after deductible)
Emergency and urgent care		
Emergency Department visit (waived if admitted)	$100 copay	$150 copay (after deductible)
Urgent care visit	$25 copay	$30 copay
Ambulance service	$100 copay	$150 copay (after deductible)
Prescription drugs		
Plan pharmacy (up to a 30-day supply)	Generic: $10 copay/Brand: $35 copay	
Mail-order (up to a 100-day supply)	Generic: $20 copay/Brand: $70 copay	

MONTHLY RATES

Age on Jan. 1, 2011	Rate Area 1		Rate Area 6	
	Copayment 25	Deductible 30/1500	Copayment 25	Deductible 30/1500
<1	$792	$567	$753	$538
1–18	396	283	375	270
19	418	295	397	280
20	443	314	421	299
21	469	331	445	314
22	493	346	469	329
23	515	360	489	341
24	532	374	504	355
25	554	385	527	367
26	571	399	542	379
27	588	413	559	392
28	605	426	574	404
29	623	436	593	414
20	639	448	606	426
31	654	459	622	436
32	671	469	637	445
33	681	477	647	453
34	688	486	654	462
35	695	494	661	469
36	702	501	666	476
37	708	510	673	484
38	715	516	680	491
39	724	523	688	498
40	731	530	695	503
41	737	537	700	510
42	744	544	707	516
43	753	554	715	527
44	759	566	722	537
45	768	578	729	549
46	775	591	736	562
47	785	605	746	574
48	797	620	758	589
49	809	635	768	603
50	821	652	780	620
51	836	669	793	635
52	853	686	810	652
53	870	702	826	666
54	889	720	844	685
55	914	739	868	702
56	941	754	894	717
57	970	770	921	731
58	999	785	950	746
59	1025	800	974	759
60	1025	800	974	759
61	1025	800	974	759
62	1025	800	974	759
63	1025	800	974	759
64	1025	800	974	759
65+	2046	2046	1944	1944

SERVICE AREA ZIP CODES

Rate Area 1

94002
94005
94010–11
94014–28
94030
94035
94037–44
94060–66
94070
94074
94080
94083
94085–89
94101–05
94107–12
94114–34
94137
94139–47
94151
94156
94158–64
94172
94177
94188
94199
94203–09
94211
94229–30
94232
94234–37
94239–40
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94246–50
94252
94254
94256–59
94261–63
94267–69
94271
94273–74
94277
94279–80
94282–91
94293–98
94301–06
94309
94401–04
94497
94501–03
94505–31
94533–53
94555–83
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94595–99
94601–15
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94649
94659–62
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94701–10
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94903–04
94912–15
94920
94922–31
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94937–42
94945–57
94960
94963–66
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95008–09
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95013–15
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95687–88
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95762–63
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95776
95798–99
95811–38
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95851–53
95860
95864–67
95894
95899
95903
95961

Rate Area 6

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93232
93242
93601–02
93604
93606–07
93609
93611–14
93616
93618–19
93623–27
93630–31
93636–39
93643–46
93648–54
93656–57
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93662
93666–69
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93701–12
93714–18
93720–30
93737
93741
93744–45
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93755
93760–61
93764–65
93771–79
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93790–94
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95201–13
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FREQUENTLY ASKED QUESTIONS

The following questions are among those commonly asked by our members about their Kaiser Permanente coverage. Look them over and, if you need more information or have any additional questions, feel free to call our Member Service Call Center at **1-800-464-4000** from 7 a.m. to 7 p.m., weekdays, and 7 a.m. to 3 p.m., weekends (except holidays). Our correspondence address can be found on page 7.

What will my Kaiser Permanente HIPAA plan rate be?
Your rate is based on the cost of care for the specific combination of benefits covered by the Kaiser Permanente health plan. Your rate also depends upon your address and your age on January 1, 2011. Please refer to the "Monthly Rates" section to find your rate.

What is the major difference between the HIPAA Copayment 25 and the HIPAA Deductible 30/1500 plans?
- The HIPAA Copayment 25 plan does not have a deductible. Members can pay a copayment for covered services from the first day of coverage.
- The HIPAA Deductible 30/1500 plan has a $1,500 deductible for most covered services.

Can I add dependents on my new HIPAA plan?
At the time you enroll, you may also enroll dependents. Each of your family members will be enrolled under his or her own plan at a separate rate. This allows you to easily select different plans for different family members. For example, you may want the extra coverage of our HIPAA Copayment 25 for a young child, but you might like the lower premiums of our HIPAA Deductible 30/1500 for yourself.

Can I add a dependent to an existing HIPAA plan?
No. Except for newborns and newly adopted children, dependents are not eligible for enrollment in a HIPAA plan unless they were enrolled when you became a HIPAA plan subscriber. To enroll a newborn or newly adopted child, you must submit a *Change of Enrollment Form* within 31 days after the dependent becomes eligible. Mail requests to the Direct Pay correspondence address on page 7.

If my account terminates, how do I request reinstatement?
You can contact us at **1-888-236-4490** to request reinstatement on a terminated account. A representative will be happy to review your account to determine if your account is eligible for reinstatement.

When is my health plan premium due?
Be sure that your monthly payment is **received on or before the last day of the month preceding coverage**. For example, to be eligible for the month of January, full payment must be received on or before December 31. Late payment may result in termination of your health coverage.

Make your check or money order payable to **Kaiser Foundation Health Plan, Inc.**, and write your **account number** (found on the remittance portion of your monthly statement) on the check. Do not send postdated checks or cash. **Checks returned by the bank are subject to a $25 fee.**

Each billing statement shows the amount you need to pay for each month and the date it is due. Please return the remittance portion with each payment. Please include the remittance portion and payment only; use a separate envelope for payments for any family members who have Medicare billing statements.

Do not write on the face of the remittance portion of the statement. If you have comments or questions, please write them on a separate page and include your name, subscriber's signature, account number or medical record number, and daytime phone number with area code. Comments and questions should not be mailed with your payment. Please mail them to the correspondence address on page 7.

FREQUENTLY ASKED QUESTIONS

Can I make payments using an ATM/debit card or credit card?
Yes. If you choose to pay by credit card, debit card, or bank account, you may register and make payments online at **kp.org/payonline**. If you pay by credit card, debit card, or check, you may also make payments over the phone. Simply call us at **1-800-403-5945**. You will need a copy of your most recent bill on hand, along with your bank account or credit card information, when utilizing this option. Accepted credit cards are Visa, MasterCard, American Express, and Discover.

How can I elect to make payments using electronic funds transfer?
Call the Member Service Call Center at **1-800-464-4000** or write to the correspondence address below to request an *Electronic Funds Transfer Form*. Please continue to pay as you normally would until the transfer is in effect.

Do I have a grace period?
No. Kaiser Permanente is a prepaid health care plan, and payments are due on or before the last day of the month preceding the month of coverage. However, if you elect electronic funds transfer, we withdraw funds from your bank on the fifth day of the month of coverage instead of on the last working day of the month preceding the month of coverage.

Can I make payment arrangements on a Kaiser Permanente HIPAA plan account?
No. Kaiser Permanente does not accept partial payments or make payment arrangements.

Can I make one payment for multiple accounts?
Yes, through a service called **consolidated billing**. Consolidated billing allows multiple subscriber accounts to receive a single bill.

Who is eligible for consolidated billing?
Our consolidated billing is designed for two or more subscribers who live in the same region and would like to receive a single bill. **Please note that Northern and Southern California accounts cannot be combined.**

How do I sign up for consolidated billing?
Call the Member Service Call Center at **1-800-464-4000** to request a *Consolidated Billing Authorization Form*. Please continue to pay using your regular bills until you receive the new consolidated bill.

How do I make address or name changes to my account?
- To change your address, call **1-800-464-4000** to request an *Address Change Form*. Complete and return the form to the Direct Pay correspondence address below.
- To change a name on your account, please send a written request, including the signature of the subscriber or person with the name change, to the Direct Pay correspondence address below.

Direct Pay correspondence address
Use the following address to:
- Request additional information
- Request address changes
- Request name changes
- Add a dependent
- Remove a dependent

Kaiser Permanente
Direct Pay Correspondence
P.O. Box 23059
San Diego, CA 92193-3059

HOW TO APPLY

1 Review the *Membership Agreements* for the Kaiser Permanente HIPAA Copayment 25 and the Kaiser Permanente HIPAA Deductible 30/1500 plans to help determine which plan is best for you.

2 Check to see if you live or work in our service area by making sure your home or work ZIP code is listed on page 5.

3 Complete and sign the following four-page enrollment application. If you are applying to enroll your family, each family member must submit a separate application. Please make copies of the enclosed application. Check the box at the top of the application for the plan you are applying for. Enclose certificates of creditable coverage or other proof of creditable coverage. **Note: Your request for enrollment will be delayed if proof of creditable coverage is not provided.**

4 Keep a copy of your completed and signed application(s) for your records.

5 Return the original application and proof of creditable coverage in the enclosed postage-paid envelope. You may also fax the forms to **(858) 614-3344**.

Our mailing address is:
Kaiser Permanente
P.O. Box 23059
San Diego, CA 92193-3059

Please note: If you choose to apply and are accepted for the Kaiser Permanente HIPAA Copayment 25 plan, you may change to the Kaiser Permanente HIPAA Deductible 30/1500 plan at a later date. However, if you choose to apply and are accepted for the HIPAA Deductible 30/1500 plan, you will not be able to change to the HIPAA Copayment 25 plan after 30 days following your effective date.

KAISER PERMANENTE®

Kaiser Permanente HIPAA Plan Enrollment Application

For which plan would you like to apply?
❒ HIPAA Copayment 25 ❒ HIPAA Deductible 30/1500

Kaiser Permanente Health Insurance Portability and Accountability Act Plan

To be eligible for the Kaiser Permanente Health Insurance Portability and Accountability Act (HIPAA) Plan, you must meet all of the eligibility requirements contained in the *Membership Agreements* provided with this application. Please read the requirements carefully. Before submitting your completed application, please make sure that you do the following:

- Enclose all certificates of creditable coverage from your former employer(s) or provider(s) of health coverage.
- If there are any periods of creditable coverage for which you are unable to obtain a certificate of creditable coverage from a former employer or provider of health care coverage, please complete the "Certification of Creditable Coverage" section of the application for these time periods.
- Complete a separate application for each family member applying for coverage.
- A parent or legal guardian should complete the application for applicants under age 18 and sign in the designated places.
- Please print, using ink only.

APPLICANT INFORMATION

LAST NAME	FIRST NAME	MI
HOME ADDRESS (NO P.O. BOXES PLEASE)		
CITY	STATE	ZIP
MAILING ADDRESS (IF DIFFERENT THAN ABOVE) OR P.O. BOX		
CITY	STATE	ZIP

HOME PHONE ( )	WORK PHONE ( )	FAX ( )
MARITAL STATUS: ❒ SINGLE ❒ MARRIED	NAME OF FINANCIALLY RESPONSIBLE PARTY	RELATIONSHIP

INSURANCE COVERAGE

Please provide all health insurance information for the last two years below, beginning with the most recent insurance coverage first.

COMPANY	SUBSCRIBER	
ADDRESS		
CITY	STATE	ZIP
When did or will your insurance or health coverage end?	MM DD YY / /	POLICY OR ACCOUNT NO.

COMPANY	SUBSCRIBER	
ADDRESS		
CITY	STATE	ZIP
When did or will your insurance or health coverage end?	MM DD YY / /	POLICY OR ACCOUNT NO.

HIPAA COVERAGE ELIGIBILTY QUESTIONNAIRE

Please read the HIPAA requirements below to determine whether all five are true statements. Then check the appropriate response(s) at right. Your response(s) will instruct Kaiser Permanente whether you qualify for enrollment in a HIPAA plan. A parent or legal guardian should complete this section for applicants under age 18.

1. I have at least 18 months of creditable coverage without a break in coverage of more than 63 days at any time. *Creditable coverage* means continuous health coverage during the qualifying 18-month period immediately preceding this application for enrollment. If there have been multiple coverages during that qualifying period and/or a combination of individual and group coverage, a) there can be a break of no more than 63 days between coverages, and b) the final coverage must have been group coverage. For more information about the types of health coverage that may qualify for creditable coverage, please refer to your *Membership Agreement*, or call us at **1-800-464-4000**. ❒ True ❒ False

2. My most recent health coverage was through a group health plan, a governmental plan, or a church plan. ❒ True ❒ False

   If you answered *True*, please provide the following information:

   Employer _____

   Address _____

   Telephone number _____

3. If I was eligible for continuation of coverage under federal (COBRA) or state (Cal-COBRA) laws, I enrolled in any available continuation coverage and paid all applicable premiums for the entire period for which I was eligible. ❒ True ❒ False

4. I do not currently have other health coverage, and I am not eligible for coverage under any group health plan, governmental plan, church plan, state-administered Medicaid program, or Medicare. ❒ True ❒ False

5. My most recent coverage was not terminated for fraud or failure to pay premiums. ❒ True ❒ False

Please enclose a certificate or certificates of creditable coverage. For any periods of creditable coverage for which you are unable to provide a certificate of creditable coverage, please complete the "Certification of Creditable Coverage" section of the application or provide other proof.

CERTIFICATION OF CREDITABLE COVERAGE

Please complete this section only for periods of creditable coverage for which you are unable to provide a certificate of creditable coverage.

I have applied for membership in the Kaiser Permanente Health Insurance Portability and Accountability Act (HIPAA) Plan. I understand that one of the eligibility requirements for the Kaiser Permanente HIPAA Plan is that at the time of application I must have 18 months of creditable coverage and must not have had a significant break between those periods (as explained in the *Membership Agreement*). I am unable to provide a certificate of creditable coverage for each period of creditable coverage and submit this certification of creditable coverage in support of my application for enrollment. I understand that Health Plan may verify the information that I provide, and I agree to provide to Health Plan all information that Health Plan requests to verify the information contained in this certification of creditable coverage or in my application. I understand that Health Plan can refuse to enroll me or terminate my membership if the information that I provide is incomplete, inaccurate, or untrue.

I have periods of *creditable coverage* as described below for which I am unable to provide a certificate of creditable coverage. A parent or legal guardian should complete this section for applicants under age 18.

NAME OF INSURANCE COMPANY/PROVIDER	SUBSCRIBER	ACCOUNT ID		EFFECTIVE DATE	END DATE
ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER ( )	
NAME OF INSURANCE COMPANY/PROVIDER	SUBSCRIBER	ACCOUNT ID		EFFECTIVE DATE	END DATE
ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER ( )	
NAME OF INSURANCE COMPANY/PROVIDER	SUBSCRIBER	ACCOUNT ID		EFFECTIVE DATE	END DATE
ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER ( )	
NAME OF INSURANCE COMPANY/PROVIDER	SUBSCRIBER	ACCOUNT ID		EFFECTIVE DATE	END DATE
ADDRESS	CITY	STATE	ZIP	TELEPHONE NUMBER ( )	

STATEMENT OF ACCOUNTABILITY

I am applying for Kaiser Permanente Health Insurance Portability and Accountability Act Plan membership. I attest that the information I have provided is true and correct to the best of my knowledge. I authorize Health Plan to verify all the information that I have furnished in this application and agree to cooperate with Health Plan in verifying the information. I understand that Health Plan may refuse to accept my application if I fail to cooperate. I agree to abide by the provisions of the *Membership Agreement* and Health Plan policies.

Signature

I have read each section of the application. I attest and agree to the information as provided in the Statement of Accountability.

X ____

Applicant/Financially responsible party **Date**

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 1560.503-1), certain benefit-related disputes), any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Membership Agreement*.

X	
Applicant/Financially responsible party	**Today's date**

X	
Applicant's spouse/domestic partner	**Today's date**

X	
Applicant/Dependent (age 18 or over)	**Today's date**

Important: Required signatures—all Applicants age 18 or over must sign and date above on the appropriate signature line (financially responsible party, spouse, dependent). Parent or legal guardian must sign for dependents under the age of 18.

AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION

I authorize the person or entity to which this authorization is addressed, its agents, officers, and employees (*Addressee*) to release to Kaiser Foundation Health Plan any information in your possession that it requires in order to verify my eligibility for the Kaiser Permanente Health Insurance Portability and Accountability Act Plan.

The Addressee may provide information concerning my insurance or health care coverage provided by or made available through the Addressee, including but not limited to the following information: the effective date of my health care coverage; the termination date of such coverage; whether the Addressee imposed a waiting period, probationary period, or affiliation period upon me in connection with such coverage; whether the coverage was terminated due to fraud or nonpayment; and whether I was able to continue such coverage by electing continuation coverage available in accordance with either state or federal law and, if I was, whether I elected and exhausted all such coverage.

I authorize the Addressee to furnish such information to Health Plan in any form or fashion which Health Plan requests, including via telephone. If Health Plan requests a certificate of creditable coverage from the Addressee, I authorize the Addressee to furnish directly to Health Plan a certificate of creditable coverage.

This authorization shall be effective as of the date signed by me and shall remain in effect for a period of one year after that date.

Nothing in this authorization shall be construed to authorize the release of any information regarding my medical history, mental or physical condition or treatment, or claims experience.

A copy of this authorization shall be as effective as an original.

X _____

Applicant's signature (Use ink only.) **Date**
Parent or legal guardian should sign for Applicants under age 18.

Return application by fax to (858) 614-3344, or mail to Kaiser Permanente, P.O. Box 23059, San Diego, CA 92193-3059.

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern California Region

A nonprofit corporation

Individual Plan Membership Agreement and Disclosure Form and Evidence of Coverage for Kaiser Permanente HIPAA Individual Plan

Copayment 25 Plan

Highlights	
Copayments and Coinsurance	
Most consultations and exams	$25 per visit
Hospital inpatient care	$200 per day
Outpatient surgery	$100 per procedure
Emergency Department visits	$100 per visit
Generic drugs	$10 for up to a 30-day supply
Brand-name drugs	$35 for up to a 30-day supply

Member Service Call Center
Weekdays 7 a.m.–7 p.m.; weekends 7 a.m.–3 p.m.
(except holidays)
1-800-464-4000 toll free
1-800-777-1370 (toll free TTY for the hearing/speech impaired)
kp.org

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

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

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

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Health Plan Benefits and Coverage Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Annual Out-of-Pocket Maximum for Certain Services	**$2,500 per calendar year**
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to this amount.	
Deductible or Lifetime Maximum	None
Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations and exams	$25 per visit
Routine physical maintenance exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling	No charge
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge
Eye exams for refraction	No charge
Hearing exams	No charge
Urgent care consultations and exams	$25 per visit
Physical, occupational, and speech therapy	$25 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$100 per procedure
Allergy injections (including allergy serum)	$5 per visit
Most immunizations (including vaccines)	No charge
Most X-rays and laboratory tests	$10 per encounter
Preventive X-rays, screenings, and laboratory tests as described in the "Benefits and Cost Sharing" section	No charge
MRI, most CT, and PET scans	$50 per procedure
Health education:	
Covered individual health education counseling and programs	No charge
Covered group education programs	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$200 per day
Emergency Health Coverage	**You Pay**
Emergency Department visits	$100 per visit
Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).	
Ambulance Services	**You Pay**
Ambulance Services	$100 per trip
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary guidelines:	
Generic items from a Plan Pharmacy	$10 for up to a 30-day supply, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply
Generic refills from our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply

Prescription Drug Coverage	You Pay
Brand-name items from a Plan Pharmacy	$35 for up to a 30-day supply, $70 for a 31- to 60-day supply, or $105 for a 61- to 100-day supply
Brand-name refills from our mail-order service	$35 for up to a 30-day supply or $70 for a 31- to 100-day supply
Durable Medical Equipment	**You Pay**
The durable medical equipment for home use listed in the "Benefits and Cost Sharing" section in accord with our durable medical equipment formulary guidelines (most durable medical equipment is **not covered**) .	20% Coinsurance
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization and intensive psychiatric treatment programs (up to 30 days per calendar year)	$200 per day
Outpatient mental health evaluations and treatments:	
Up to a total of 20 individual and group visits per calendar year that include Services for mental health evaluation or treatment	$25 per individual visit $12 per group visit
Up to 20 additional group visits in the same calendar year that meet Medical Group criteria	$12 per visit
Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the "Benefits and Cost Sharing" section.	
Chemical Dependency Services	**You Pay**
Inpatient detoxification	$200 per day
Individual outpatient chemical dependency consultations and treatment	$25 per visit
Group outpatient chemical dependency treatment	$5 per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge
Other	**You Pay**
Skilled Nursing Facility care (up to 100 days per benefit period)	No charge
Hospice care	No charge

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

Introduction

This *Individual Plan Membership Agreement and Disclosure Form and Evidence of Coverage (Membership Agreement and Evidence of Coverage)* describes the health care coverage of "Kaiser Permanente HIPAA Individual Copayment 25 Plan." This *Membership Agreement and Evidence of Coverage,* the Rate Sheet which is incorporated into this *Membership Agreement and Evidence of Coverage* by reference, and any amendments, constitute the legally binding contract between Health Plan (Kaiser Foundation Health Plan, Inc.) and the Subscriber. For benefits provided under any other Health Plan program, refer to that plan's evidence of coverage.

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

The "Kaiser Permanente HIPAA Individual Plan" does not include dependent coverage, so each person in your family who is accepted for coverage must enroll as a Subscriber under his or her own *Membership Agreement and Evidence of Coverage* as described under "Who Is Eligible" and "How to Enroll" in the "Premiums, Eligibility, and Enrollment" section. Any references in this *Membership Agreement and Evidence of Coverage* to Dependents, Spouses, or children are not applicable to your coverage.

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

Note: The Health Plan Benefits and Coverage Matrix is located in the front of this *Membership Agreement and Evidence of Coverage.*

Term of this *Membership Agreement and Evidence of Coverage*, Renewal, and Amendment

Term of this *Membership Agreement and Evidence of Coverage*

This *Membership Agreement and Evidence of Coverage* becomes effective on the membership effective date in the Subscriber's acceptance letter and will remain in effect until one of the following occurs:

- The *Membership Agreement and Evidence of Coverage* is amended as described under "Amendment of *Membership Agreement and Evidence of Coverage*" in this "Introduction" section
- There are no longer any Members in your Family who are covered under this *Membership Agreement and Evidence of Coverage*

Note: Your membership may terminate even if this *Membership Agreement and Evidence of Coverage* remains in effect for other covered Members of your Family. The "Termination of Membership" section explains how membership may terminate.

Renewal

If you comply with all the terms of this *Membership Agreement and Evidence of Coverage*, we will automatically renew this *Membership Agreement and Evidence of Coverage* each year, effective on one of the following dates:

- **January 1** if the most recent effective date of the Subscriber's coverage is between January 1 and June 30
- **July 1** if the most recent effective date of the Subscriber's coverage is between July 1 and December 31

Terms of the *Membership Agreement and Evidence of Coverage* will remain the same when we renew it unless we have amended the *Membership Agreement and Evidence of Coverage* as described under "Amendment of *Membership Agreement and Evidence of Coverage*" in this "Term of this *Membership Agreement and Evidence of Coverage*, Renewal, and Amendment" section.

Amendment of *Membership Agreement and Evidence of Coverage*

In accord with "Notices" in the "Miscellaneous Provisions" section, **we may amend this *Membership Agreement and Evidence of Coverage* (including Premiums and benefits) at any time by sending written notice to the Subscriber at least 30 days before the effective date of the amendment**. The

amendment may become effective earlier than the end of the period for which you have already paid your Premiums, and it may require you to pay additional Premiums for that period. All amendments are deemed accepted by the Subscriber unless the Subscriber gives us written notice of non-acceptance within 30 days of the date of the notice, in which case this *Membership Agreement and Evidence of Coverage* terminates the day before the effective date of the amendment.

If we notified the Subscriber that we have not received all necessary governmental approvals related to this *Membership Agreement and Evidence of Coverage*, we may amend this *Membership Agreement and Evidence of Coverage* by giving written notice to the Subscriber after receiving all necessary governmental approval, in accord with "Notices" in the "Miscellaneous Provisions" section. Any such government-approved provisions go into effect on January 1, 2011 (unless the government requires a later effective date).

About Kaiser Permanente

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

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

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

Definitions

Some terms have special meaning in this *Membership Agreement and Evidence of Coverage*. When we use a term with special meaning in only one section of this *Membership Agreement and Evidence of Coverage*, we define it in that section. The terms in this "Definitions" section have special meaning when capitalized and used in any section of this *Membership Agreement and Evidence of Coverage*.

Charges: "Charges" means the following:

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

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

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

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

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

Dependent: A Member who meets the eligibility requirements as a Dependent.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to himself or herself or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

Emergency Services: All of the following with respect to an Emergency Medical Condition:

- A medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post Stabilization Care and not Emergency Services)

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

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

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

Medical Group: The Permanente Medical Group, Inc., a for-profit professional corporation.

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

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

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

***Membership Agreement and Evidence of Coverage*:** This *Membership Agreement and Disclosure Form and Evidence of Coverage* document, which describes your Health Plan coverage. This *Membership Agreement and Evidence of Coverage*, the Rate Sheet which is incorporated into this *Membership Agreement and Evidence of Coverage* by reference, and any amendments, constitute the legally binding contract between Health Plan and the Subscriber.

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

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

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

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

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

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

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

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

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

Plan Physician: Any licensed physician who is 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, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that we designate as a Plan Provider.

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

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

Premiums: Periodic membership charges paid by or on behalf of each Member. Premiums are in addition to any Cost Sharing.

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Please refer to our website at **kp.org** for a directory of Primary Care Physicians, except that the directory is subject to change without notice. For the current list of physicians that are available as Primary Care Physicians, please call the personal physician selection department at the phone number listed in *Your Guidebook*.

Rate Sheet: The document that lists premiums for the "Kaiser Permanente HIPAA Individual Plan." The Premium for your coverage under this *Membership Agreement and Evidence of Coverage* is listed in the Rate Sheet included with the Subscriber's acceptance letter, unless the Rate Sheet has been amended as described under "Term and amendment of this *Membership Agreement and Evidence of Coverage*" in the "Introduction" section.

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

Service Area: The following counties are entirely inside our Service Area: Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, San Mateo, Solano, and Stanislaus. Portions of the following counties are also inside our Service Area, as indicated by the ZIP codes below for each county:

- Amador: 95640, 95669
- El Dorado: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762
- Fresno: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–30, 93737, 93741, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–79, 93786, 93790–94, 93844, 93888
- Kings: 93230, 93232, 93242, 93631, 93656
- Madera: 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720
- Mariposa: 93601, 93623, 93653
- Napa: 94503, 94508, 94515, 94558–59, 94562, 94567 (except that Knoxville is not in our Service Area), 94573–74, 94576, 94581, 94589–90, 94599, 95476
- Placer: 95602–04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95692, 95703, 95722, 95736, 95746–47, 95765
- Santa Clara: 94022–24, 94035, 94039–43, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–36, 95138–41, 95148, 95150–61, 95164, 95170, 95172–73, 95190–94, 95196
- Sonoma: 94515, 94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448,

95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, 95492

- Sutter: 95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 95836–37
- Tulare: 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
- Yolo: 95605, 95607, 95612, 95616–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99
- Yuba: 95692, 95903, 95961

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

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

Services: Health care services or items ("health care" includes both physical health care and mental health care).

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Spouse: The Subscriber's legal husband or wife. For the purposes of this *Membership Agreement and Evidence of Coverage*, the term "Spouse" includes the Subscriber's same-sex spouse if the Subscriber and spouse are a couple who meet all of the requirements of Section 308(c) of the California Family Code, the Subscriber's registered domestic partner who meets all of the requirements of Sections 297 or 299.2 of the California Family Code, or the Subscriber's domestic partner as determined by Health Plan.

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and for whom we have received applicable Premiums.

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

Premiums, Eligibility, and Enrollment

Premiums

You must prepay the Premiums listed on the Rate Sheet, applicable to your coverage, for each month on or before the last day of the preceding month. **We may amend the Premiums listed on the Rate Sheet upon 30-days prior written notice, as described under "Term and amendment of this *Membership Agreement and Evidence of Coverage*" in the "Introduction" section.** Also, your Premiums may change as follows:

- When you move to a new rate area, any change in Premiums will take effect at the same time the change in your coverage becomes effective
- When the Subscriber progresses to a new age band, any change in Premiums will take effect upon renewal

Only Members for whom we have received the appropriate Premiums are entitled to coverage under this *Membership Agreement and Evidence of Coverage*, and then only for the period for which we have received payment.

If a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Health Plan or Plan Providers (or any of their activities), then upon 30-days prior written notice we may increase Premiums to include your share of the new or increased tax or charge. Your share is determined by dividing the number of enrolled Members in your Family by the total number of Members enrolled in our Northern California Region.

Who Is Eligible

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

HIPAA eligibility

To enroll, you must meet the definition of an eligible individual under the Health Insurance Portability and Accountability Act (HIPAA). To be considered an eligible individual under HIPAA, you must meet all of the following requirements:

- Your most recent health care coverage must have been provided through your employment and under an employee welfare benefit plan, a church plan, or a government plan (all as defined by the Employee Retirement Income Security Act or "ERISA"). Your former employee benefit plan or issuer of health care coverage must provide you a certificate demonstrating the time periods you were insured or had health care coverage so that you can prove that you have the minimum amount of creditable coverage required. This is called a "certificate of creditable coverage." If you do not have or cannot obtain a certificate of creditable coverage, certification information may be provided by other means acceptable to us
- You cannot have any other health insurance coverage
- You cannot be eligible for coverage under an employee welfare benefit plan, Medicare, or Medi-Cal
- You have elected and exhausted any continuation coverage available under COBRA and Cal-COBRA
- You must have at least 18 months of creditable coverage and have not had a significant break between any of the periods of creditable coverage (please refer to "Creditable coverage" below for details)

Creditable coverage. "Creditable coverage" means health care coverage provided in connection with any of the following:

- A group health plan, including governmental or church plans
- Group or individual health insurance coverage
- Medicare
- Medicaid
- A military-sponsored health care program for members or certain former members of the uniformed services, and for their dependents
- A program of the Indian Health Service
- A state high risk pool
- The Federal Employees Health Benefits Program
- A public health plan, including any plan established or maintained by a state, the federal government, a foreign country, or any political subdivision of a state, the federal government, or a foreign country
- A health benefit plan provided for Peace Corps members
- A State Children's Health Insurance Program
- Any other form of health care coverage that meets the definition of creditable coverage under HIPAA

Coverage that consists solely of one or more of the following is **not** creditable coverage:

- Accident-only coverage
- Coverage for on-site medical clinics
- Disability income insurance
- Medicare supplemental coverage
- Limited-scope long term care, dental, or vision coverage
- Credit-only insurance
- Worker's compensation insurance
- Automobile medical payment insurance
- Coverage issued as a supplement to liability insurance
- Coverage which is payable with or without regard to fault that is legally required to be contained in any policy of liability insurance
- Any other insurance or coverage that does not meet the definition of creditable coverage under state or federal law

Consecutive periods of creditable coverage can be added together provided that a "significant break" between them has not occurred. A "significant break" occurs if 63 consecutive days pass between the date one period of creditable coverage ends and the earlier of either: (1) the date on which a substantially completed application for health care coverage was submitted to an issuer of a succeeding period of creditable coverage which became effective or (2) the first day of any employer-imposed waiting period or an affiliation period applicable to that succeeding coverage. If a significant break in creditable coverage has occurred, all periods of creditable coverage before that significant break are disallowed and you cannot include those days in determining whether you have 18 months of creditable coverage.

Periods of an employer-imposed waiting period or affiliation period cannot be counted as periods of

creditable coverage. If you have more than one source of creditable coverage on the same day, all the creditable coverage for that day counts as a single day of creditable coverage.

Service Area eligibility requirements

You must live or work in our Service Area at the time you enroll. The "Definitions" section describes our Service Area and how it may change.

If you live in or move to the service area of another Region after enrollment, you are not eligible for membership under this Northern California Region *Membership Agreement and Evidence of Coverage*:

- **Regions outside California.** If you move to the service area of a Region outside California, you may be able to apply for membership in that Region by contacting the member or customer service department there, but the plan, including coverage, premiums, and eligibility requirements, might not be the same. For the purposes of this eligibility rule, the service areas of the Regions outside California may change on January 1 of each year and are currently the District of Columbia and parts of Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington. For more information, please call our Member Service Call Center
- **Southern California Region's service area.** If you move to our Southern California Region's service area, we will transfer your membership to the individual plan in that Region that is most similar to this plan. All terms and conditions in your application for membership, including the Arbitration Agreement, will continue to apply. We will provide you with a Southern California Region membership agreement and evidence of coverage, the effective date of coverage, and a Kaiser Permanente ID card with a new medical record number on it. Please refer to the Rate Sheet for the premiums that apply in the Southern California Region. For more information, please call our Member Service Call Center

If you move anywhere else outside our Service Area after enrollment, you can continue your membership as long as you meet all other eligibility requirements. However, you must receive covered Services from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

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

Persons barred from enrolling

- You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause
- Persons who have had entitlement to receive Services through Health Plan terminated three times in any 12-month period for failure to pay individual (nongroup) plan premiums cannot enroll for 12 months after the second termination date. For the purposes of this paragraph, a termination does not count if we reinstated your entitlement to receive Services because you made full payment on or before the next scheduled payment due date following the one you missed

Members with Medicare

If you are (or become) eligible for Medicare, you are not eligible for coverage under the "Kaiser Permanente HIPAA Individual Plan."

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

How to Enroll

This plan does not include dependent coverage, so each person in your family who is accepted for coverage must enroll as a Subscriber under his or her own *Membership Agreement and Evidence of Coverage*.

To request enrollment in the Kaiser Permanente HIPAA Individual Plan, you must complete a Health Plan application. We must receive the application within 63 days after one of the following events:

- The date your health care coverage through an employee welfare benefit plan, a church plan, or a governmental plan ends
- The date your health care coverage through COBRA or Cal-COBRA ends, or any continuation coverage available under any state law after COBRA or Cal-COBRA coverage ends
- You received notice from us that we denied your application for Kaiser Permanente for Individuals and Families (KPIF) and you must have applied for KPIF enrollment within 63 days of the two events described immediately above

If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You will have 45 days to pay the bill. If you do not send us the Premium payment by the due date on the bill, you will not be enrolled in the Kaiser Permanente HIPAA Individual Plan.

Changing your benefit plan

If you choose the Deductible 30/1500 Plan, you cannot change to the Copayment 25 Plan later unless you request it within 30 days of your effective date of coverage under the Deductible 30/1500 Plan. If you choose the Copayment 25 Plan, you can change to the Deductible 30/1500 Plan at any time.

Effective date of coverage

If we approve your enrollment application, we will notify you of the date your coverage will begin.

How to Obtain Services

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

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

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

Routine Care

If you need the following Services, you should schedule an appointment:

- Preventive care (Services that protect against disease, promote health, or detect disease at its earliest stages before noticeable symptoms develop)
- Periodic follow-up care (regularly scheduled follow-up care, such as visits to monitor a chronic condition)
- Other care that is not Urgent Care

To make a non-urgent appointment, please refer to *Your Guidebook* for appointment telephone numbers, or go to our website at **kp.org** to request an appointment online.

Urgent Care

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 telephone number at a Plan Facility. Please refer to *Your Guidebook* for appointment and advice telephone numbers.

For information about Out-of-Area Urgent Care, please refer to "Urgent Care" in the "Emergency Services and Urgent Care" section.

Not Sure What Kind of Care You Need?

Sometimes it's difficult to know what kind of care you need, so we have licensed health care professionals available to assist you by phone 24 hours a day, seven days a week. Here are some of the ways they can help you:

- They can answer questions about a health concern, and instruct you on self-care at home if appropriate
- They can advise you about whether you should get medical care, and how and where to get care (for example, if you are not sure whether your condition is an Emergency Medical Condition, they can help you decide whether you need Emergency Services or Urgent Care, and how and where to get that care)
- They can tell you what to do if you need care and a Plan Medical Office is closed

You can reach one of these licensed health care professionals by calling the appointment or advice telephone number listed in *Your Guidebook*. When you call, a trained support person may ask you questions to help determine how to direct your call.

Your Personal Plan Physician

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

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

To learn how to select a personal Plan Physician, please refer to *Your Guidebook* or call our Member Service Call Center. You can find a directory of our Plan Physicians on our website at **kp.org**. For the current list of physicians that are available as Primary Care Physicians, please call the personal physician selection department at the phone number listed in *Your Guidebook*. You can change your personal Plan Physician for any reason.

Getting a Referral

Referrals to Plan Providers

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

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

Although a referral or prior authorization is not required to receive care from these providers, the provider may have to get prior authorization for certain Services in accord with "Medical Group authorization procedure for certain referrals" in this "Getting a Referral" section.

Medical Group authorization procedure for certain referrals

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

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

is Medically Necessary. For more information about our soft goods formulary, please refer to "Ostomy and Urological Supplies" in the "Benefits and Cost Sharing" section

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

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

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

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your physician will be informed of the scope of the authorized Services. If the Medical Group does not authorize all of the Services, Health Plan will send you a written decision and explanation within two business days after the decision is made. The letter will include information about your appeal rights, which are described in the "Dispute Resolution" section. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request.

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

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

Second Opinions

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

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

- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have concerns about the diagnosis or plan of care

You can either ask your Plan Physician to help you arrange for a second medical opinion, or you can make an appointment with another Plan Physician. If the Medical Group determines that there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, the Medical Group will authorize a referral to a Non–Plan Physician for a Medically Necessary second opinion.

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

Contracts with Plan Providers

How Plan Providers are paid

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

Financial liability

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

Breach of contract

We will give you written notice within a reasonable time if any contracted provider breaches a contract with us, or is not able to provide contracted Services, if you might be materially and adversely affected.

Termination of a Plan Provider's contract and completion of Services

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements. We will give you 60 days prior written notice (or as soon as reasonably possible) if a contracted provider group or hospital terminates a contract with us and you might be materially and adversely affected.

In addition, if you are currently receiving covered Services in one of the following cases from a Plan Hospital or a Plan Physician (or certain other providers) when our contract with the provider ends (for reasons other than medical disciplinary cause or criminal activity), you may be eligible for limited coverage of that terminated provider's Services:

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

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

- Your Health Plan coverage is in effect on the date you receive the Service
- You are receiving Services in one of the cases listed above from the terminated Plan Provider on the provider's termination date

- The provider agrees to our standard contractual terms and conditions, such as conditions pertaining to payment and to providing Services inside our Service Area
- The Services to be provided to you would be covered Services under this *Membership Agreement and Evidence of Coverage* if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from the termination date of the Plan Provider

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

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

Visiting Other Regions

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

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

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

Your ID Card

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

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

Getting Assistance

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

Member Services

Most Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Call Center representatives are available to assist you weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m. (except holidays) toll free at 1-800-464-4000 or 1-800-777-1370 (TTY for the deaf, hard of hearing, or speech impaired). For your convenience, you can also contact us through our website at **kp.org**.

Member Services representatives at our Plan Facilities and Member Service Call Center can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace your ID card. These representatives can also help you if you need to file a claim as described in the "Emergency Services and Urgent Care" section or with any issues as described in the "Dispute Resolution" section.

Interpreter services

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

Plan Facilities

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

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available from Plan Hospital Emergency Departments as described in *Your Guidebook* (please refer to *Your Guidebook* for Emergency Department locations in your area)
- Same-day Urgent Care appointments are available at many locations (please refer to *Your Guidebook* for Urgent Care locations in your area)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services Department (refer to *Your Guidebook* for locations in your area)

Plan Hospitals and Plan Medical Offices

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

Alameda

- Medical Offices: 2417 Central Ave.

Antioch

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

Campbell

- Medical Offices: 220 E. Hacienda Ave.

Clovis

- Medical Offices: 2071 Herndon Ave.

Daly City

- Medical Offices: 395 Hickey Blvd.

Davis

- Medical Offices: 1955 Cowell Blvd.

Elk Grove

- Medical Offices: 9201 Big Horn Blvd.

Fairfield

- Medical Offices: 1550 Gateway Blvd.

Folsom

- Medical Offices: 2155 Iron Point Rd.

Fremont

- Hospital and Medical Offices: 39400 Paseo Padre Pkwy.

Fresno

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

Gilroy

- Medical Offices: 7520 Arroyo Circle

Hayward

- Hospital and Medical Offices: 27400 Hesperian Blvd.

Lincoln

- Medical Offices: 1900 Dresden Dr.

Livermore

- Medical Offices: 3000 Las Positas Rd.

Manteca

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

Martinez

- Medical Offices: 200 Muir Rd.

Milpitas

- Medical Offices: 770 E. Calaveras Blvd.

Modesto

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

Mountain View

- Medical Offices: 555 Castro St.

Napa

- Medical Offices: 3285 Claremont Way

Novato

- Medical Offices: 97 San Marin Dr.

Oakhurst

- Medical Offices: 40595 Westlake Dr.

Oakland

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

Petaluma

- Medical Offices: 3900 Lakeville Hwy.

Pinole

- Medical Offices: 1301 Pinole Valley Rd.

Pleasanton

- Medical Offices: 7601 Stoneridge Dr.

Rancho Cordova

- Medical Offices: 10725 International Dr.

Redwood City

- Hospital and Medical Offices: 1150 Veterans Blvd.

Richmond

- Hospital and Medical Offices: 901 Nevin Ave.

Rohnert Park

- Medical Offices: 5900 State Farm Dr.

Roseville

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

Sacramento

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

San Bruno

- Medical Offices: 901 El Camino Real

San Francisco

- Hospital and Medical Offices: 2425 Geary Blvd.

San Jose

- Hospital and Medical Offices: 250 Hospital Pkwy.

San Rafael

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

Santa Clara

- Hospital and Medical Offices: 700 Lawrence Expwy.

Santa Rosa

- Hospital and Medical Offices: 401 Bicentennial Way

Selma

- Medical Offices: 2651 Highland Ave.

South San Francisco

- Hospital and Medical Offices: 1200 El Camino Real

Stockton

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

Tracy

- Medical Offices: 2185 W. Grant Line Rd.

Turlock

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

Union City

- Medical Offices: 3553 Whipple Rd.

Vacaville

- Hospital and Medical Offices: 1 Quality Dr.

Vallejo

- Hospital and Medical Offices: 975 Sereno Dr.

Walnut Creek

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

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

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

Your Guidebook to Kaiser Permanente Services (Your Guidebook)

Plan Medical Offices and Plan Hospitals for your area are listed in greater detail in *Your Guidebook to Kaiser Permanente Services (Your Guidebook)*. *Your Guidebook* describes the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services. It includes additional facilities that are not listed in this

"Plan Facilities" section. Also, it explains how to use our Services and make appointments, lists hours of operation, and includes a detailed telephone directory for appointments and advice. *Your Guidebook* provides other important information, such as preventive care guidelines and your Member rights and responsibilities. *Your Guidebook* is subject to change and is periodically updated. You can get a copy by visiting our website at **kp.org** or by calling our Member Service Call Center.

Emergency Services and Urgent Care

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital Emergency Department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non–Plan Providers anywhere in the world as long as the Services would have been covered under the "Benefits and Cost Sharing" section (subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section) if you had received them from Plan Providers.

Emergency Services are available from Plan Hospital Emergency Departments 24 hours a day, seven days a week.

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that this condition is Stabilized. We cover Post-Stabilization Care from a Non–Plan Provider, including inpatient care at a Non–Plan Hospital, only if we provide prior authorization for the care or if otherwise required by applicable law ("prior authorization" means that we must approve the Services in advance).

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

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

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

Cost Sharing

The Cost Sharing for covered Emergency Services and Post-Stabilization Care is the Cost Sharing required for Services provided by Plan Providers as described in the "Benefits and Cost Sharing" section:

- Please refer to "Outpatient Care" for the Cost Sharing for Emergency Department visits
- The Cost Sharing for other covered Emergency Services and Post-Stabilization Care is the Cost Sharing that you would pay if the Services were not Emergency Services or Post-Stabilization Care. For example, if you are admitted as an inpatient to a Non–Plan Hospital for Post-Stabilization Care and we give prior authorization for that care, your Cost Sharing would be the Cost Sharing listed under "Hospital Inpatient Care"

Services not covered under this "Emergency Services" section

Coverage for the following Services is described in other sections of this *Membership Agreement and Evidence of Coverage*:

- Follow-up care and other Services that are not Emergency Services or Post-Stabilization Care described in this "Emergency Services" section (refer to the "Benefits and Cost Sharing" section for

coverage, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)

- Out-of-Area Urgent Care (refer to "Out-of-Area Urgent" care under "Urgent Care" in this "Emergency Services and Urgent Care" section)

Urgent Care

Inside the Service Area

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 telephone number at a Plan Facility. Please refer to *Your Guidebook* for appointment and advice telephone numbers.

Out-of-Area Urgent Care

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

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

You do not need prior authorization for Out-of-Area Urgent Care. We cover Out-of-Area Urgent Care you receive from Non–Plan Providers as long as the Services would have been covered under the "Benefits and Cost Sharing" section (subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section) if you had received them from Plan Providers.

Cost Sharing

The Cost Sharing for covered Urgent Care is the Cost Sharing required for Services provided by Plan Providers as described in the "Benefits and Cost Sharing" section:

- Please refer to "Outpatient Care" for the Cost Sharing for Urgent Care consultations and exams
- The Cost Sharing for other covered Urgent Care is the Cost Sharing that you would pay if the Services were not Urgent Care. For example, if the Urgent Care you receive includes an X-ray, your Cost Sharing for the X-ray would be the Cost Sharing for an X-ray listed under "Outpatient Imaging, Laboratory, and Special Procedures"

Services not covered under this "Urgent Care" section

Coverage for the following Services is described in other sections of this *Membership Agreement and Evidence of Coverage*:

- Follow-up care and other Services that are not Urgent Care or Out-of-Area Urgent Care described in this "Urgent Care" section (refer to the "Benefits and Cost Sharing" section for coverage, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider as described in this "Emergency Services and Urgent Care" section, or emergency ambulance Services described under "Ambulance Services" in the "Benefits and Cost Sharing" section, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us. Also, you may be required to pay and file a claim for any Services prescribed by a Non–Plan Provider as part of covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care even if you receive the Services from a Plan Provider, such as a Plan Pharmacy.

We will reduce any payment we make to you or the Non–Plan Provider by applicable Cost Sharing. Also, we will reduce our payment by any amounts paid or payable (or that in the absence of this plan would have been payable) for the Services under any insurance policy, or any other contract or coverage, or any government program except Medicaid. If payment under the other insurance or program is not made within a reasonable period of time, we will pay for covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care received from Non–Plan Providers if you:

- Assign all rights to payment to us and agree to cooperate with us in obtaining payment
- Allow us to obtain any relevant information from the other insurance or program
- Provide us with any information and assistance we need to obtain payment from the other insurance or program

How to file a claim

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

- As soon as possible, send us a completed claim form. You can get a claim form by visiting our website at **kp.org** or by calling our Member Service Call Center

toll free at 1-800-464-4000 or 1-800-390-3510 (TTY users call 1-800-777-1370). One of our representatives will be happy to assist you if you need help completing our claim form

- If you have paid for Services, you must include any bills and receipts from the Non–Plan Provider with your claim form
- To request that we pay a Non–Plan Provider for Services, you must include any bills from the Non–Plan Provider with your claim form. If the Non–Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If you later receive any bills from the Non–Plan Provider for covered Services (other than bills for your Cost Sharing amount), please call our Member Service Call Center toll free at 1-800-390-3510 for assistance
- The completed claim form and any bills or receipts must be mailed to the following address as soon as possible after receiving the care:
  Kaiser Foundation Health Plan, Inc.
  Claims Department
  P.O. Box 12923
  Oakland, CA 94604-2923

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

We will send you our written decision within 45 business days after we receive the claim unless we request additional information from you or the Non–Plan Provider. If we request additional information, we will send our written decision no later than 45 business days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in the letter, we will make our decision based on the information we have. If our decision is not fully in your favor, we will tell you the reasons and how to file a grievance as described under "Grievances" in the "Dispute Resolution" section.

Benefits and Cost Sharing

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

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
  - health care items and services for preventive care
  - health care items and services for diagnosis, assessment, or treatment
  - health education covered under "Health Education" in this "Benefits and Cost Sharing" section
  - other health care items and services
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except where specifically noted to the contrary in the sections listed below for the following Services:
  - emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- You receive the Services from Plan Providers inside our Service Area, except where specifically noted to the contrary in the sections listed below for the following Services:
  - authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
  - emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
  - hospice care as described under "Hospice Care" in this "Benefits and Cost Sharing" section
- The Medical Group has given prior authorization for the Services if required under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

The only Services we cover under this *Membership Agreement and Evidence of Coverage* are those that this "Benefits and Cost Sharing" section says that we cover, subject to exclusions and limitations described in this "Benefits and Cost Sharing" section and to all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. The "Exclusions, Limitations, Coordination of Benefits, and Reductions" section describes exclusions, limitations, reductions, and

coordination of benefits provisions that apply to all Services that would otherwise be covered. When an exclusion or limitation applies only to a particular benefit, it is listed in the description of that benefit in this "Benefits and Cost Sharing" section. Also, please refer to:

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

Cost Sharing

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

- If you are receiving covered inpatient hospital or Skilled Nursing Facility Services on the effective date of this *Membership Agreement and Evidence of Coverage*, you pay the Cost Sharing in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Sharing in effect on the date you receive the Services
- For items ordered in advance, you pay the Cost Sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription
- If you receive more than one Service from a provider, or Services from more than one provider, you may be required to pay separate Cost Sharing amounts for each Service and each provider. For example, if you receive both preventive Services and non-preventive Services in the same visit, you may have to pay separate Cost Sharing for each Service received during that visit. Similarly, if your physician requests the assistance of another Plan Provider during a procedure, you may have to pay separate Cost Sharing amounts for the Services provided by each Plan Provider. If you have questions about Cost Sharing, please contact our Member Service Call Center
- In some cases, we may agree to bill you for your Cost Sharing amounts

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

Copayments and Coinsurance

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

Annual out-of-pocket maximum

There is a limit to the total amount of Cost Sharing you must pay under this *Membership Agreement and Evidence of Coverage* in a calendar year for all of the covered Services listed below that you receive in the same calendar year. The limit is **$2,500** per calendar year.

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

- Administered drugs
- Ambulance Services
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)
- Diabetic testing supplies and equipment and insulin-administration devices
- Emergency Department visits
- Home health care
- Hospice care
- Hospital care
- Imaging, laboratory, and special procedures
- Intensive psychiatric treatment programs
- Outpatient surgery
- Prosthetic and orthotic devices
- Services performed during an office visit (including professional Services such as dialysis treatment, health education counseling and programs, and physical, occupational, and speech therapy)
- Skilled Nursing Facility care

Keeping track of the maximum. When you pay Cost Sharing that applies toward the annual out-of-pocket

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

Preventive Care Services

We cover a variety of preventive care Services, which are Services that do one or more of the following:

- Protect against disease, such as in the use of immunizations
- Promote health, such as counseling on tobacco use
- Detect disease in its earliest stages before noticeable symptoms develop, such as screening for breast cancer

This "Preventive Care Services" section explains Cost Sharing for some preventive care Services, but does not otherwise explain coverage. These preventive care Services are subject to all coverage requirements described in other parts of this "Benefits and Cost Sharing" section and all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. For example, we cover a preventive care Service that is an outpatient laboratory Service only if it is covered as described under the "Outpatient Imaging, Laboratory, and Special Procedures" section, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.

We cover at **no charge** the preventive care Services listed on our "Health Reform Preventive Services List - CA regions." This list is subject to change at any time and is available from Member Services or on our website at **kp.org/formsandpubs**. If you receive any other covered Services during a preventive care visit, you will pay the applicable Cost Sharing for those Services.

The following are examples of preventive Services that are included in our "Health Reform Preventive Services List - CA Regions":

- Eye exams for refraction and preventive vision screenings
- Family planning counseling and programs
- Flexible sigmoidoscopies and colonoscopies
- Health education counseling and programs
- Hearing exams and screenings
- Immunizations (including vaccines) administered in a Plan Medical Office
- Preventive counseling, such as STD prevention counseling
- Routine preventive imaging services, including the following:
  - abdominal aortic aneurysm screening
  - bone density scans
  - mammograms
  - ultrasounds
- Routine physical maintenance exams, including well-woman exams
- Routine preventive retinal photography screenings
- Scheduled prenatal care exams and first postpartum follow-up consultation and exam
- Tuberculosis tests
- Well-child preventive care exams (0–23 months)
- The following laboratory tests:
  - routine preventive laboratory tests, such as cervical cancer screenings
  - cholesterol tests (lipid panel and profile)
  - diabetes screening (fasting blood glucose tests)
  - fecal occult blood tests
  - HIV tests
  - prostate specific antigen tests
  - certain sexually transmitted disease (STD) tests

If you receive both preventive and non-preventive Services in the same visit, you may have to pay separate Cost Sharing amounts for each Service received during that visit. For example, if you go in for a preventive exam, and your physician diagnoses you with an infection, you may have to pay separate Cost Sharing amounts for both the preventive exam and for the Services performed to diagnose a condition.

Outpatient Care

We cover the following outpatient care subject to the Cost Sharing indicated:

- Most primary and specialty care consultations and exams: **a $25 Copayment per visit**
- Routine physical maintenance exams, including well-woman exams: **no charge**
- Well-child preventive exams for Members through age 23 months: **no charge**
- Family planning counseling, or to obtain internally implanted time-release contraceptives or intrauterine

devices (IUDs) prescribed in accord with our drug formulary guidelines: **no charge**

- After confirmation of pregnancy, the normal series of regularly scheduled preventive care prenatal care exams and the first postpartum follow-up consultation and exam: **no charge**
- Alcohol and substance abuse interventions: **no charge**
- Developmental screenings to diagnose and assess potential developmental delays: **no charge**
- Immunizations (including vaccines) administered to you in a Plan Medical Office: **no charge**
- Flexible sigmoidoscopies: **no charge**
- Colonoscopies: **no charge**
- Allergy injections (including allergy serum): **a $5 Copayment per visit**
- Outpatient surgery: **a $100 Copayment per procedure** if it is provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. Any other outpatient surgery is covered at **a $25 Copayment per procedure**
- Outpatient procedures (other than surgery): **a $100 Copayment per procedure** if a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. All outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above are covered **at the Cost Sharing that would otherwise apply for the procedure** in this "Benefits and Cost Sharing" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Special Procedures")
- Voluntary termination of pregnancy: **a $25 Copayment per procedure**
- Physical, occupational, and speech therapy: **a $25 Copayment per visit**
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program: **a $25 Copayment per day**
- Urgent Care consultations and exams: **a $25 Copayment per visit**
- Emergency Department visits: **a $100 Copayment per visit**. The Emergency Department Copayment does not apply if you are admitted directly to the hospital as an inpatient for covered Services, or if you are admitted for observation and are then admitted directly to the hospital as an inpatient for covered Services (for inpatient care, please refer to "Hospital Inpatient Care" in this "Benefits and Cost Sharing" section). However, the Emergency Department Copayment does apply if you are admitted for observation but are not admitted as an inpatient
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician: **no charge**
- Acupuncture Services provided for the treatment of nausea or as part of a multidisciplinary pain management program for the treatment of chronic pain: **a $25 Copayment per visit**
- Blood, blood products, and their administration: **no charge**
- Administered drugs (drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials) prescribed in accord with our drug formulary guidelines, if administration or observation by medical personnel is required and they are administered to you in a Plan Medical Office or during home visits: **no charge**
- Some types of outpatient consultations and exams may be available as group appointments, which we cover at **a $12 Copayment per visit**

Services not covered under this "Outpatient Care" section

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

- Bariatric Surgery
- Chemical Dependency Services
- Dental and Orthodontic Services
- Dialysis Care
- Durable Medical Equipment for Home Use
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Mental Health Services
- Ostomy and Urological Supplies
- Outpatient Imaging, Laboratory, and Special Procedures
- Outpatient Prescription Drugs, Supplies, and Supplements

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

Hospital Inpatient Care

We cover the following inpatient Services at **a $200 Copayment per day** in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals inside our Service Area:

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

Services not covered under this "Hospital Inpatient Care" section

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

- Bariatric Surgery
- Chemical Dependency Services
- Dental and Orthodontic Services
- Dialysis Care
- Hospice Care
- Mental Health Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Skilled Nursing Facility Care
- Transplant Services

Ambulance Services

Emergency

We cover at **a $100 Copayment per trip** Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) if one of the following is true:

- You reasonably believe that you have an Emergency Medical Condition and you reasonably believe that your condition requires the clinical support of ambulance transport services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

If you receive emergency ambulance Services that are not ordered by a Plan Provider, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us. Please refer to "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section for how to file a claim for reimbursement.

Nonemergency

Inside our Service Area, we cover nonemergency ambulance and psychiatric transport van Services at **a $100 Copayment per trip** if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health.

These Services are covered only when the vehicle transports you to or from covered Services.

Ambulance Services exclusion

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

Bariatric Surgery

We cover hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, special procedures, and Plan Physician Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

- You complete the Medical Group–approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success
- A Plan Physician who is a specialist in bariatric care determines that the surgery is Medically Necessary

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

If you live 50 miles or more from the facility to which you are referred for a covered bariatric surgery, we will reimburse you for certain travel and lodging expenses if you receive prior written authorization from the Medical Group and send us adequate documentation including receipts. We will not, however, reimburse you for any travel or lodging expenses if you were offered a referral to a facility that is less than 50 miles from your home. We will reimburse authorized and documented travel and lodging expenses as follows:

- Transportation for you to and from the facility up to $130 per round trip for a maximum of three trips (one pre-surgical visit, the surgery, and one follow-up visit), including any trips for which we provided reimbursement under any other evidence of coverage
- Transportation for one companion to and from the facility up to $130 per round trip for a maximum of two trips (the surgery and one follow-up visit), including any trips for which we provided reimbursement under any other evidence of coverage
- One hotel room, double-occupancy, for you and one companion not to exceed $100 per day for the pre-surgical visit and the follow-up visit, up to two days per trip, including any hotel accommodations for which we provided reimbursement under any other evidence of coverage
- Hotel accommodations for one companion not to exceed $100 per day for the duration of your surgery stay, up to four days, including any hotel accommodations for which we provided reimbursement under any other evidence of coverage

Services not covered under this "Bariatric Surgery" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Chemical Dependency Services

Inpatient detoxification

We cover hospitalization at **a $200 Copayment per day** in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Outpatient chemical dependency care

We cover the following Services for treatment of chemical dependency:

- Day-treatment programs
- Intensive outpatient programs
- Individual and group chemical dependency counseling
- Outpatient chemical dependency consultation and treatment for withdrawal symptoms

You pay the following for these covered Services:

- Individual chemical dependency consultations and treatment: **a $25 Copayment per visit**
- Group chemical dependency treatments: **a $5 Copayment per visit**

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

Transitional residential recovery Services

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

Services not covered under this "Chemical Dependency Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Chemical dependency Services exclusion

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

Dental and Orthodontic Services

We do not cover most dental and orthodontic Services, but we do cover some dental and orthodontic Services as described in this "Dental and Orthodontic Services" section.

Dental Services for radiation treatment

We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck at **a $25 Copayment per visit** if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental anesthesia

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

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

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

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

Dental and orthodontic Services for cleft palate

We cover dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic Services, if they meet all of the following requirements:

- The Services are an integral part of a reconstructive surgery for cleft palate that we are covering under "Reconstructive Surgery" in this "Benefits and Cost Sharing" section
- A Plan Provider provides the Services or the Medical Group authorizes a referral to a Non-Plan Provider who is a dentist or orthodontist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)

You pay the following for these dental and orthodontic Services for cleft palate:

- Consultations and exams: **a $25 Copayment per visit**
- Hospital inpatient care: **a $200 Copayment per day**
- Outpatient surgery: **a $100 Copayment per procedure** if it is provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. Any other outpatient surgery: **a $25 Copayment per procedure**
- Outpatient procedures (other than surgery): **a $100 Copayment per procedure** if a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. All outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above are covered **at the Cost Sharing that would otherwise apply for the procedure** in this "Benefits and Cost Sharing" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under

"Outpatient Imaging, Laboratory, and Special Procedures")

Services not covered under this "Dental and Orthodontic Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Outpatient imaging, laboratory, and special procedures (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient administered drugs (refer to "Outpatient Care"), except that we cover outpatient administered drugs under "Dental anesthesia" in this "Dental and Orthodontic Services" section
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Dialysis Care

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

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

After you receive appropriate training at a dialysis facility we designate, we also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside our Service Area at **no charge**. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

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

- Inpatient dialysis care: **a $200 Copayment per day**
- One routine office consultation or exam per month with the multidisciplinary nephrology team: **no charge**
- All other consultations or exams: **a $25 Copayment per visit**
- Hemodialysis treatment at a Plan Facility: **a $25 Copayment per visit**

Services not covered under this "Dialysis Care" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Durable medical equipment for home use (refer to "Durable Medical Equipment for Home Use")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Dialysis Care exclusions

- Comfort, convenience, or luxury equipment, supplies and features
- Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

Durable Medical Equipment for Home Use

Inside our Service Area, we cover the durable medical equipment specified in this "Durable Medical Equipment for Home Use" section for use in your home (or another location used as your home) in accord with our durable medical equipment formulary guidelines. Durable medical equipment for home use is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. Covered durable medical equipment (including repair or replacement of covered equipment, unless due to loss or misuse) is provided at **20% Coinsurance**. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.

Inside our Service Area, we cover the following durable medical equipment for use in your home (or another location used as your home):

- For diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other drugs)
- Standard curved handle or quad cane and replacement supplies
- Standard or forearm crutches and replacement supplies
- Dry pressure pad for a mattress
- Nebulizer and supplies
- Peak flow meters
- IV pole
- Tracheostomy tube and supplies
- Enteral pump and supplies
- Bone stimulator
- Cervical traction (over door)
- Phototherapy blankets for treatment of jaundice in newborns

Outside the Service Area

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

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

About our durable medical equipment formulary

Our durable medical equipment formulary includes the list of durable medical equipment that has been approved by our Durable Medical Equipment Formulary Executive Committee for our Members. Our durable medical equipment formulary was developed by a multidisciplinary clinical and operational work group with review and input from Plan Physicians and medical professionals with durable medical equipment expertise (for example: physical, respiratory, and enterostomal therapists and home health). A multidisciplinary Durable Medical Equipment Formulary Executive Committee is responsible for reviewing and revising the durable medical equipment formulary. Our durable medical equipment formulary is periodically updated to keep pace with changes in medical technology and clinical practice.

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

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

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Durable medical equipment for home use exclusion

- Comfort, convenience, or luxury equipment or features

Health Education

We cover a variety of health education counseling, programs, and materials that your personal Plan

Physician or other Plan Providers provide during a visit covered under another part of this "Benefits and Cost Sharing" section.

We also cover a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for tobacco cessation, stress management, and chronic conditions (such as diabetes and asthma). Kaiser Permanente also offers health education counseling, programs, and materials that are not covered, and you may be required to pay a fee.

For more information about our health education counseling, programs, and materials, please contact your local Health Education Department or our Member Service Call Center, refer to *Your Guidebook*, or go to our website at **kp.org**.

You pay the following for these covered Services:

- Group health education programs: **no charge**
- Individual counseling and programs when the visit is solely for health education: **no charge**
- Health education provided during an outpatient consultation or exam covered in another part of this "Benefits and Cost Sharing" section: **no additional Cost Sharing beyond the Cost Sharing required in that other part of this "Benefits and Cost Sharing" section**
- Covered health education materials: **no charge**

Hearing Services

We cover the following:

- Routine preventive hearing screenings: **no charge**
- Hearing exams to determine the need for hearing correction: **no charge**

Services not covered under this "Hearing Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Hearing Services exclusions

- Hearing aids and tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. We cover home health care at **no charge** only if all of the following are true:

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

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

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

Note: If a visit by a nurse, medical social worker, or physical, occupational, or speech therapist lasts longer than two hours, then each additional increment of two hours counts as a separate visit. If a visit by a home health aide lasts longer than four hours, then each additional increment of four hours counts as a separate visit. For example, if a nurse comes to your home for three hours and then leaves, that counts as two visits. Also, each person providing Services counts toward these visit limits. For example, if a home health aide and a nurse are both at your home during the same two hours, that counts as two visits.

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

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

Home health care exclusions

- Care of a type that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. This care is excluded even if we would cover the care if it were provided by a qualified medical professional in a hospital or a Skilled Nursing Facility
- Care in the home if the home is not a safe and effective treatment setting

Hospice Care

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

We cover the hospice Services listed below at **no charge** only if all of the following requirements are met:

- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside our Service Area or inside California but within 15 miles or 30 minutes from our Service Area (including a friend's or relative's home even if you live there temporarily)
- The Services are provided by a licensed hospice agency that is a Plan Provider
- The Services are necessary for the palliation and management of your terminal illness and related conditions

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

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

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when the Services are for the diagnosis or treatment of Mental Disorders.

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

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

- "Severe Mental Illness" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.
- A "Serious Emotional Disturbance" of a child under age 18 means mental disorders as identified in the *DSM*, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:
  - ♦ as a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either (1) the child is at risk of removal from the home or has already been removed from the home, or (2) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
  - ♦ the child displays psychotic features, or risk of suicide or violence due to a mental disorder
  - ♦ the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

Any outpatient visit limits specified under "Outpatient mental health Services" and inpatient day limits specified under "Calendar-year day limit for inpatient psychiatric hospitalization and intensive psychiatric treatment programs" do not apply to Severe Mental Illness of a person of any age and the Serious Emotional Disturbance of a child. For all other mental health conditions, we cover evaluation and treatment only when a Plan Physician or other Plan Provider who is a license health care professional acting within the scope of his or her license believes the condition will significantly improve with relatively short-term therapy.

Outpatient mental health Services

We cover the following Services when provided by Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license:

- Up to a combined visit limit of 20 individual and group visits per Member calendar year that include Services for mental health evaluation and treatment as described in this "Outpatient mental health Services" section. Members who have exhausted the 20-visit limitation and who meet Medical Group criteria may receive up to 20 additional group visits in the same calendar year
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient Services for the purpose of monitoring drug therapy

You pay the following for these covered Services:

- Individual mental health evaluation and treatment: **a $25 Copayment per visit**
- Group mental health treatment: **a $12 Copayment per visit**

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

Inpatient psychiatric hospitalization and intensive psychiatric treatment programs

Inpatient psychiatric hospitalization. Subject to the day limit described under "Calendar-year day limit for inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in this "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" section, we cover inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and Services of Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license. We cover these Services at **a $200 Copayment per day**.

Intensive psychiatric treatment programs. Subject to the day limit described under "Calendar-year day limit for inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in this "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" section, we cover at **no charge** the following intensive psychiatric treatment programs at a Plan Facility:

- Short-term hospital-based intensive outpatient care (partial hospitalization)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program

- Short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis
- Psychiatric observation for an acute psychiatric crisis

Calendar-year day limit for inpatient psychiatric hospitalization and intensive psychiatric treatment programs. There is a combined day limit of 30 days per Member per calendar year for psychiatric care described under "Inpatient psychiatric hospitalization" and "Intensive psychiatric treatment programs" in this "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" section, except that the day limit does not apply to psychiatric care for the treatment of Severe Mental Illnesses and Serious Emotional Disturbance of a child under age 18. The number of days is determined by adding up the number of days of inpatient psychiatric hospitalization and intensive psychiatric treatment program Services we cover in a calendar year that are subject to the limit as follows:

- Each day of inpatient psychiatric hospitalization counts as one day
- Two days of hospital-based intensive outpatient care (partial hospitalization) count as one day
- Three days of treatment in an intensive outpatient psychiatric treatment program count as one day
- Each day of treatment in a crisis residential program counts as one day
- Two psychiatric observation treatment periods of 23 consecutive hours or less count as one day

If you reach the day limit, we will not cover any more inpatient psychiatric hospitalization or intensive psychiatric treatment program Services in that calendar year if they are subject to the day limit.

Services not covered under this "Mental Health Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Ostomy and Urological Supplies

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

About our soft goods formulary

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

Our formulary guidelines allow you to obtain nonformulary ostomy and urological supplies (those not listed on our soft goods formulary for your condition) if they would otherwise be covered and the Medical Group determines that they are Medically Necessary as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

Ostomy and urological supplies exclusion

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Special Procedures

We cover the following Services at the Cost Sharing indicated only when prescribed as part of care covered under other headings in this "Benefits and Cost Sharing" section:

- Most diagnostic and therapeutic imaging, such as X-rays, mammograms, and ultrasounds: **a $10 Copayment per encounter** except that certain imaging procedures are covered at **a $100 Copayment per procedure** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort

- Preventive imaging, such as preventive mammograms, aortic aneurysm screenings, and bone density screenings: **no charge**
- MRI, most CT, and PET scans: **a $50 Copayment per procedure**
- Nuclear medicine: **a $10 Copayment per encounter**
- Laboratory tests (including tests for specific genetic disorders for which genetic counseling is available):
  - laboratory tests to monitor the effectiveness of dialysis: **no charge**
  - fecal occult blood tests: **no charge**
  - preventive laboratory tests and screenings, including cervical cancer screenings, prostate specific antigen tests, cholesterol tests (lipid panel and profile), diabetes screening (fasting blood glucose tests), certain sexually transmitted disease (STD) tests, and HIV tests: **no charge**
  - all other laboratory tests: **a $10 Copayment per encounter**
- Routine preventive retinal photography screenings: **no charge**
- All other diagnostic procedures provided by Plan Providers who are not physicians (such as EKGs and EEGs): **a $10 Copayment per encounter** except that certain diagnostic procedures are covered at **a $100 Copayment per procedure** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort
- Radiation therapy: **no charge**
- Ultraviolet light treatments: **no charge**

Outpatient Prescription Drugs, Supplies, and Supplements

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

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

How to obtain covered items

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

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

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

Outpatient drugs, supplies, and supplements

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

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

- Disposable needles and syringes needed for injecting covered drugs
- Inhaler spacers needed to inhale covered drugs

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

- Generic items:
  - **a $10 Copayment** for up to a 30-day supply, **a $20 Copayment** for a 31- to 60-day supply, or **a $30 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
  - **a $10 Copayment** for up to a 30-day supply or **a $20 Copayment** for a 31- to 100-day supply through our mail-order service
  - drugs prescribed for the treatment of sexual dysfunction disorders: **50% Coinsurance** for up to a 100-day supply at a Plan Pharmacy or through our mail-order service
- Brand-name items and compounded products:
  - **a $35 Copayment** for up to a 30-day supply, **a $70 Copayment** for a 31- to 60-day supply, or **a $105 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
  - **a $35 Copayment** for up to a 30-day supply or **a $70 Copayment** for a 31- to 100-day supply through our mail-order service
  - drugs prescribed for the treatment of sexual dysfunction disorders: **50% Coinsurance** for up to a 100-day supply at a Plan Pharmacy or through our mail-order service
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria) and elemental dietary enteral formula when used as a primary therapy for regional enteritis: **no charge** for up to a 30-day supply
- Emergency contraceptive pills: **no charge**
- Hematopoietic agents for dialysis: **no charge** for up to a 30-day supply
- Continuity drugs (if this *Membership Agreement and Evidence of Coverage* is amended to exclude a drug that we have been covering and providing to you under this *Membership Agreement and Evidence of Coverage*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration): **50% Coinsurance** for up to a 30-day supply in a 30-day period

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

Certain intravenous drugs, supplies, and supplements

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

Diabetes urine-testing supplies and insulin-administration devices

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

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

Day supply limit

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

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

About our drug formulary

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

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

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

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Outpatient prescription drugs, supplies, and supplements exclusions

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

Prosthetic and Orthotic Devices

We do not cover most prosthetic and orthotic devices, but we do cover devices as described in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select

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 cover a replacement device, then you pay the Cost Sharing that you would pay for obtaining that device.

Internally implanted devices

We cover prosthetic and orthotic devices, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if they are implanted during a surgery that we are covering under another section of this "Benefits and Cost Sharing" section. We cover these devices at **no charge**.

External devices

We cover the following external prosthetic and orthotic devices at **no charge**:

- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres required to hold a prosthesis every 12 months

- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

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

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Contact lenses to treat aniridia or aphakia (refer to "Vision Services")

Prosthetic and orthotic devices exclusions

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Except as otherwise described above in this "Prosthetic and Orthotic Devices" section, nonrigid supplies, such as elastic stockings and wigs
- Comfort, convenience, or luxury equipment or features
- Shoes or arch supports, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications

Reconstructive Surgery

We cover the following reconstructive surgery Services:

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

You pay the following for covered reconstructive surgery Services:

- Consultations and exams: **a $25 Copayment per visit**
- Outpatient surgery: **a $100 Copayment per procedure** if it is provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. Any other outpatient surgery: **a $25 Copayment per procedure**
- Hospital inpatient care (including room and board, drugs, and Plan Physician Services): **a $200 Copayment per day**

Services not covered under this "Reconstructive Surgery" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Dental and orthodontic Services that are an integral part of reconstructive surgery for cleft palate (refer to "Dental and Orthodontic Services")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")

Reconstructive surgery exclusions

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

Services Associated with Clinical Trials

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

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

after determining that it has a meaningful potential to benefit you

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

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

Services associated with clinical trials exclusions

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

Skilled Nursing Facility Care

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

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

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment in accord with our durable medical equipment formulary if Skilled Nursing Facilities ordinarily furnish the equipment
- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Blood, blood products, and their administration
- Medical supplies
- Physical, occupational, and speech therapy
- Respiratory therapy

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

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Transplant Services

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

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

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

tissue, or bone marrow and for treatment of complications. Our guidelines for donor Services are available by calling our Member Service Call Center

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

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

Services not covered under this "Transplant Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Vision Services

We cover the following:

- Routine preventive vision screenings: **no charge**
- Eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses: **no charge**
- Up to two Medically Necessary contact lenses, fitting, and dispensing per eye every 12 months (including lenses we covered under any other evidence of coverage) to treat aniridia (missing iris): **no charge**
- Up to six Medically Necessary aphakic contact lenses, fitting, and dispensing per eye per calendar year (including lenses we covered under any other evidence of coverage) to treat aphakia (absence of the crystalline lens of the eye) for Members through age 9: **no charge**

Services not covered under this "Vision Services" section

- Services related to the eye or vision other than Services covered under this "Vision Services" section

Vision Services exclusions

- Industrial frames
- Services for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism
- Eyeglass lenses and frames
- Contact lenses, including fitting and dispensing (except for contact lenses to treat aphakia or aniridia as described under this "Vision Services" section)
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low vision devices

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this *Membership Agreement and Evidence of Coverage* regardless of whether the services are within the scope of a provider's license or certificate. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the "Benefits and Cost Sharing" section.

Acupuncture Services

Acupuncture Services and the Services of an acupuncturist except for Services covered under "Outpatient Care" in the "Benefits and Cost Sharing" section.

Artificial insemination and conception by artificial means

All Services related to artificial insemination and conception by artificial means, such as: ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and Services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

Certain exams and Services

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

Chiropractic Services

Chiropractic Services and the Services of a chiropractor.

Cosmetic Services

Services that are intended primarily to change or maintain your appearance, except that this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "Benefits and Cost Sharing" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "Benefits and Cost Sharing" section: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after a mastectomy and prostheses to replace all or part of an external facial body part

Custodial care

Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, Skilled Nursing Facility, or inpatient hospital care.

Dental and orthodontic Services

Dental and orthodontic Services such as X-rays, appliances, implants, Services provided by dentists or orthodontists, dental Services following accidental injury to teeth, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment.

This exclusion does not apply to Services covered under "Dental and Orthodontic Services" in the "Benefits and Cost Sharing" section.

Disposable supplies

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

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

Experimental or investigational Services

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

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

This exclusion does not apply to any of the following:

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

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

Hair loss or growth treatment

Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Infertility Services

Services related to the diagnosis and treatment of infertility.

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Durable Medical Equipment," "Home Health Care," and "Hospice Care" in the "Benefits and Cost Sharing" section.

Items and services that are not health care items and services

For example, we do not cover:

- Teaching manners and etiquette

- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services that increase academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy

Massage therapy

Oral nutrition

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

This exclusion does not apply to any of the following:

- Amino acid–modified products and elemental dietary enteral formula covered under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section
- Enteral formula covered under "Prosthetic and Orthotic Devices" in the "Benefits and Cost Sharing" section

Residential care

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

Routine foot care items and services

Routine foot care items and services that are not Medically Necessary.

Services not approved by the federal Food and Drug Administration

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

This exclusion does not apply to any of the following:

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

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

Services performed by unlicensed people

Services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the Member's condition does not require that the services be provided by a licensed health care provider.

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services we would otherwise cover to treat complications of the noncovered Service. For example, if you have a noncovered cosmetic surgery, we would not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and we would cover any Services that we would otherwise cover to treat that complication.

Surrogacy

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

Transgender surgery

Travel and lodging expenses

Travel and lodging expenses, except that in some situations if the Medical Group refers you to a Non–Plan Provider as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines. Our travel and lodging guidelines are available from our Member Service Call Center.

This exclusion does not apply to reimbursement for travel and lodging expenses provided under "Bariatric Surgery" in the "Benefits and Cost Sharing" section.

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services under this *Membership Agreement and Evidence of Coverage*, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor disputes. Under these circumstances, if you have an Emergency Medical Condition, call 911 or go to the nearest hospital as described under "Emergency Services" in the "Emergency Services and Urgent Care" section, and we will provide coverage and reimbursement as described in that section.

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

Coordination of Benefits

If you have Medicare coverage, we will coordinate benefits with your Medicare coverage under Medicare rules. Medicare rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." You must give us any information we request to help us coordinate benefits. Please call our Member Service Call Center to find out which Medicare rules apply to your situation, and how payment will be handled.

Note: If you are (or become) eligible for Medicare, you are not eligible for coverage under the "Kaiser Permanente HIPAA Individual Plan."

Reductions

Employer responsibility

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

Government agency responsibility

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

Injuries or illnesses alleged to be caused by third parties

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

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

attorney, but we will be subrogated only to the extent of the total of Charges for the relevant Services.

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

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

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

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

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

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

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

Medicare benefits

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

Surrogacy arrangements

If you enter into a surrogacy arrangement, you must pay us Charges for covered Services you receive related to conception, pregnancy, or delivery in connection with that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed the compensation you are entitled to receive under the surrogacy arrangement. A surrogacy arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. Note: This "Surrogacy arrangements" section does not affect your obligation to pay Cost Sharing for these Services, but we will credit any such payments toward the amount you must pay us under this paragraph.

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

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

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

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

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

U.S. Department of Veterans Affairs

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

Workers' compensation or employer's liability benefits

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

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

Dispute Resolution

Grievances

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

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

- You are not satisfied with the quality of care you received
- You received a written denial of Services that require prior authorization from the Medical Group or a "Notice of Non-Coverage" and you want us to cover the Services
- A Plan Physician has said that Services are not Medically Necessary and you want us to cover the Services
- You were told that Services are not covered and you believe that the Services should be covered
- You received care from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services) and you want us to pay for the care
- We did not decide fully in your favor on a claim for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits and Cost Sharing" section and you want to appeal our decision
- You are dissatisfied with how long it took to get Services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility
- Your membership was terminated retroactively for a reason other than nonpayment of Premiums or contributions toward the cost of coverage
- We denied your membership application

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

- If we did not decide fully in your favor on a claim for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits and Cost Sharing" section and you want to appeal our decision, you can submit your grievance in one of the following ways:
  - to the Claims Department at the following address:
    Kaiser Foundation Health Plan, Inc.
    Special Services Unit
    P.O. Box 23280
    Oakland, CA 94623
  - by calling our Member Service Call Center at 1-800-464-4000 or 1-800-390-3510 (TTY users call 1-800-777-1370)
- For all other issues, you can submit your grievance in one of the following ways:

- to the Member Services Department at a Plan Facility (please refer to *Your Guidebook* for addresses)
- by calling our Member Service Call Center at 1-800-464-4000 (TTY users call 1-800-777-1370)
- through our website at **kp.org**

We will send you a confirmation letter within five days after we receive your grievance. We will send you our written decision within 30 days after we receive your grievance. If we do not approve your request, we will tell you the reasons and about additional dispute resolution options. Note: If we resolve your issue to your satisfaction by the end of the next business day after we receive your grievance orally, by fax, or through our website, and a Member Services representative notifies you orally about our decision, we will not send you a confirmation letter or a written decision unless your grievance involves a coverage dispute, a dispute about whether a Service is Medically Necessary, or an experimental or investigational treatment.

Expedited grievance

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

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

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

- Call our Expedited Review Unit toll free at 1-888-987-7247 (TTY users call 1-800-777-1370), which is available Monday through Saturday from 8:30 a.m. to 5 p.m. After hours, you may leave a message and a representative will return your call the next business day
- Send your written request to:
  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 23170
  Oakland, CA 94623-0170
- Fax your written request to our Expedited Review Unit toll free at 1-888-987-2252
- Deliver your request in person to your local Member Services Department at a Plan Facility

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

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

Supporting Documents

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

Who May File

The following persons may file a grievance:

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

- You may file for your conservatee if you are a court-appointed conservator
- You may file for your principal if you are an agent under a currently effective health care proxy, to the extent provided under state law
- Your physician may request an expedited grievance as described under "Expedited grievance" in this "Dispute Resolution" section

Department of Managed Health Care Complaints

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

Independent Medical Review (IMR)

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

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

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

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

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

Experimental or investigational denials

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

- Your treating physician provided us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we

cover than the therapy being requested. "Life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity

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

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

Binding Arbitration

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

Scope of arbitration

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

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *Membership Agreement and Evidence of Coverage* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. (Health Plan), including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, Services, irrespective of the legal theories upon which the claim is asserted
- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- The claim is *not* within the jurisdiction of the Small Claims Court
- If coverage under this *Membership Agreement and Evidence of Coverage* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), the claim is *not* about an "adverse benefit determination" as defined in that regulation. Note: Claims about "adverse benefit determinations" are excluded from this binding arbitration requirement only until such time as the regulation prohibiting mandatory binding arbitration of this category of claim (29 CFR 2560.503-1(c)(4)) is modified, amended, repealed, superseded, or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without further notice

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

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

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals
- KP Cal, LLC
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., or Southern California Permanente Medical Group physician

- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties
- Any employee or agent of any of the foregoing

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

Initiating arbitration

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

Serving Demand for Arbitration

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

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

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

Filing fee

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

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

Number of arbitrators

The number of arbitrators may affect the Claimant's responsibility for paying the neutral arbitrator's fees and expenses.

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

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

Payment of arbitrators' fees and expenses

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

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs

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

Rules of Procedure

Arbitrations shall be conducted according to the Rules of Procedure developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules

of Procedure may be obtained from our Member Service Call Center.

General provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondents served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

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

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

Termination of Membership

Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2011, your last minute of coverage was at 11:59 p.m. on December 31, 2010). You will be billed as a non-Member for any Services you receive after your membership terminates. When your membership terminates, Health Plan and Plan Providers have no further liability or responsibility under this *Membership Agreement and Evidence of Coverage*, except as provided under "Payments after Termination" in this "Termination of Membership" section.

How You May Terminate Your Membership

You may terminate your membership by sending written notice, signed by the Subscriber, to the address below. Your membership will terminate at 11:59 p.m. on the last day of the month in which we receive your notice. Also, you must include with your notice all amounts payable related to this *Membership Agreement and Evidence of Coverage*, including Premiums, for the period prior to your termination date.

Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 23059
San Diego, CA 92193-3059

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership will end at 11:59 p.m. on the last day of that month. For example, if you become ineligible on December 5, 2010, your termination date is January 1, 2011, and your last minute of coverage is at 11:59 p.m. on December 31, 2010.

Termination for Cause

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

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

After your first 24 months of individuals and families coverage, we may not terminate you for cause solely because you gave us incorrect or incomplete material information in your Health Coverage Application.

If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future. We may also report criminal fraud and other illegal acts to the authorities for prosecution.

Termination for Nonpayment of Premiums

If we terminate this *Membership Agreement and Evidence of Coverage* because we did not receive the required Premiums when due, then the membership of the Subscriber will end retroactively at 11:59 p.m. on the last day of the most recent month for which we received a full Premium payment. This retroactive period will not exceed 60 days before the date we mail the Subscriber a notice confirming termination of membership (a "Termination Notice").

If we do not receive full Premium payment on or before the 20th day of the coverage month, we will send a notice of nonreceipt of payment (a "Late Notice") to the Subscriber's address of record. This Late Notice will include the following information:

- A statement that we have not received full Premium payment and that we will terminate this *Membership Agreement and Evidence of Coverage* for nonpayment if we do not receive the required Premiums within 30 days after the date we mailed the Late Notice
- The specific date and time when the membership of the Subscriber will end if we do not receive the required Premiums

We will mail a Termination Notice to the Subscriber's address of record if we do not receive full Premium payment within 30 days after the date we mailed the Late Notice. The Termination Notice will include the following information:

- A statement that we have terminated this *Membership Agreement and Evidence of Coverage* for nonpayment of Premiums
- The specific date and time when the membership of the Subscriber ended
- Information explaining whether or not the Subscriber can reinstate this *Membership Agreement and Evidence of Coverage*

Reinstatement after termination for nonpayment of Premiums

Persons terminated for nonpayment of Premiums may not enroll in Health Plan even after paying all amounts owed unless we approve the enrollment.

If we terminate this *Membership Agreement and Evidence of Coverage* for nonpayment of Premiums, we will permit reinstatement of this *Membership Agreement and Evidence of Coverage* three times during any 12-month period if we receive the amounts owed within 15 days of the date of the Late Notice. We will not reinstate this *Membership Agreement and Evidence of Coverage* if you do not obtain reinstatement of your terminated *Membership Agreement and Evidence of Coverage* within the required 15 days, or if we terminate the *Membership Agreement and Evidence of Coverage* for nonpayment of Premiums more than three times in a 12-month period.

Termination for Discontinuance of a Product

We may terminate your membership if we discontinue offering this product as permitted or required by law. If we continue to offer other individual (nongroup) products, we may terminate your membership under this product by sending you written notice at least 90 days before the termination date. You will be able to enroll in any other product we are then offering in the individual (nongroup) market if you meet all eligibility requirements (except for any medical review requirement). If we discontinue offering all individual (nongroup) products, we may terminate your membership by sending you written notice at least 180 days before the termination date.

Payments after Termination

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

- Within 30 days, refund any amounts we owe for Premiums you paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Emergency Services and Urgent Care" and "Dispute Resolution" sections

We will deduct any amounts you owe Health Plan or Plan Providers from any payment we make to you.

State Review of Membership Termination

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

"Department of Managed Health Care Complaints" in the "Dispute Resolution" section).

Miscellaneous Provisions

Administration of this *Membership Agreement and Evidence of Coverage*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this *Membership Agreement and Evidence of Coverage*.

Advance directives

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

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

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

Membership Agreement and Evidence of Coverage binding on Members

By electing coverage or accepting benefits under this *Membership Agreement and Evidence of Coverage*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *Membership Agreement and Evidence of Coverage*.

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 *Membership Agreement and Evidence of Coverage*.

Assignment

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

Attorney and advocate fees and expenses

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

Claims review authority

We are responsible for determining whether you are entitled to benefits under this *Membership Agreement and Evidence of Coverage* and we have the discretionary authority to review and evaluate claims that arise under this *Membership Agreement and Evidence of Coverage*. We conduct this evaluation independently by interpreting the provisions of this *Membership Agreement and Evidence of Coverage*. If coverage under this *Membership Agreement and Evidence of Coverage* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), then we are a "named claims fiduciary" to review claims under this *Membership Agreement and Evidence of Coverage*.

Governing law

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

Health Insurance Counseling and Advocacy Program (HICAP)

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

No waiver

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

Nondiscrimination

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

sexual orientation, physical or mental disability, or genetic information.

Notices

Our notices to you will be sent to the most recent address we have for the Subscriber, except that if the Subscriber has chosen to receive these membership agreement and evidence of coverage documents online we will notify the Subscriber at the most recent email address we have for the Subscriber when notices related to amendment of this *Membership Agreement and Evidence of Coverage* are posted on our website at **kp.org**. The Subscriber is responsible for notifying us of any change in address. Subscribers who move (or change their e-mail address if the Subscriber has chosen to receive these membership agreement and evidence of coverage documents on our website) should call our Member Service Call Center as soon as possible to give us their new address. If a Member does not reside with the Subscriber, he or she should contact our Member Service Call Center to discuss alternate delivery options.

Other formats for Members with disabilities

You can request a copy of this *Membership Agreement and Evidence of Coverage* in an alternate format (Braille, audio, electronic text file, or large print) by calling our Member Service Call Center.

Overpayment recovery

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

Privacy practices

Kaiser Permanente will protect the privacy of your protected health information. We also require contracting providers to protect your protected health information. Your protected health information is individually-identifiable information (oral, written, or electronic) about your health, health care services you receive, or payment for your health care. You may generally see and receive copies of your protected health information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your protected health information.

We may use or disclose your protected health information for treatment, health research, payment, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give protected health information to others, such as government agencies or in judicial actions. We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices*, which provides additional information about our privacy practices and your rights regarding your protected health information is available and will be furnished to you upon request. To request a copy, please call our Member Service Call Center. You can also find the notice at your local Plan Facility or on our website at kp.org.

Public policy participation

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

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

Telephone access (TTY)

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

Helpful Information

Your Guidebook to Kaiser Permanente Services (Your Guidebook)

Please refer to *Your Guidebook* for helpful information about your coverage, such as:

- The types of covered Services that are available from each Plan Facility in your area
- How to use our Services and make appointments
- Hours of operation
- Appointments and advice phone numbers

You can get a copy of *Your Guidebook* by visiting our website at **kp.org** or by calling our Member Service Call Center.

How to Reach Us

Appointments

If you need to make an appointment, please call us or visit our website:

Call	The appointment phone number at a Plan Facility (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for phone numbers)
Website	**kp.org** for routine (non-urgent) appointments with your personal Plan Physician or another Primary Care Physician

Not sure what kind of care you need?

If you need advice on whether to get medical care, or how and when to get care, we have licensed health care professionals available to assist you by phone 24 hours a day, 7 days a week:

Call	The appointment or advice phone number at a Plan Facility (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for phone numbers)

Member Services

If you have questions or concerns about your coverage, how to obtain Services, or the facilities where you can receive care, you can reach us by calling, writing, or visiting our website:

Call	**1-800-464-4000** **1-800-390-3510 (TTY)** Weekdays 7 a.m. to 7 p.m., and weekends 7 a.m. to 3 p.m. (except holidays)
Write	Member Services Department at a Plan Facility (refer to *Your Guidebook* for addresses)
Website	**kp.org**

Authorization for Post-Stabilization Care

If you need to request authorization for Post-Stabilization Care as described under "Emergency Services" in the "Emergency Services and Urgent Care" section, please call us:

Call	**1-800-225-8883** or the notification telephone number on your Kaiser Permanente ID card **711 (TTY)** Call any time

Help with claim forms for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

If you need a claim form to request payment or reimbursement for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits and Cost Sharing" section, or if you need help completing the form, you can reach us by calling or by visiting our website.

Call	**1-800-464-4000** or **1-800-390-3510** **1-800-777-1370 (TTY)** Weekdays 7 a.m. to 7 p.m., and weekends 7 a.m. to 3 p.m. (except holidays)
Website	**kp.org**

Submitting claims for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

If you need to submit a completed claim form for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits and Cost Sharing" section, or if you need to submit other information that we request about your claim, send it to our Claims Department:

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

Payment Responsibility

This "Payment Responsibility" section briefly explains who is responsible for payments related to the health care coverage described in this *Membership Agreement and Evidence of Coverage.* Payment responsibility is more fully described in other sections of the *Membership Agreement and Evidence of Coverage* as described below:

- The Subscriber is responsible for paying Premiums (refer to "Premiums" in the "Premiums, Eligibility, and Enrollment" section)
- You are responsible for paying Cost Sharing for covered Services (refer to "Cost Sharing" in the "Benefits and Cost Sharing" section)

- If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider, or if you receive emergency ambulance Services, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us (refer to "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)
- If you receive Services from Non–Plan Providers that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services) and you want us to pay for the care, you must submit a grievance (refer to "Grievances" in the "Dispute Resolution" section)
- If you have Medicare, we will coordinate benefits with the other coverage (refer to "Coordination of Benefits" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- In some situations, you or a third party may be responsible for reimbursing us for covered Services (refer to "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- You are responsible for paying the full price for noncovered Services

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern California Region

A nonprofit corporation

Individual Plan Membership Agreement and Disclosure Form and Evidence of Coverage for Kaiser Permanente HIPAA Individual Plan

Deductible 30/1500 Plan

Highlights	
Deductible for certain Services	$1,500 per calendar year
Copayments and Coinsurance after Deductible is met:	
Most consultations and exams.....	$30 per visit (Deductible doesn't apply)
Hospital inpatient care.....	$500 per day after Deductible
Outpatient surgery	$250 per procedure after Deductible
Emergency Department visits	$150 per visit after Deductible
Generic drugs	$10 for up to a 30-day supply (Deductible doesn't apply)
Brand-name drugs	$35 for up to a 30-day supply (Deductible doesn't apply)

Member Service Call Center
Weekdays 7 a.m.–7 p.m.; weekends 7 a.m.–3 p.m.
(except holidays)
1-800-464-4000 toll free
1-800-777-1370 (toll free TTY for the hearing/speech impaired)
kp.org

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

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

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

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Health Plan Benefits and Coverage Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Annual Out-of-Pocket Maximum for Certain Services	**$3,500 per calendar year**
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services, plus all your Deductible payments, add up to this amount.	
Deductible for Certain Services as specified below	**$1,500 per calendar year**
You must pay Charges for Services you receive in a calendar year until you reach this Deductible amount.	
Lifetime Maximum	None
Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations and exams	$30 per visit (Deductible doesn't apply)
Routine physical maintenance exams	No charge (Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Deductible doesn't apply)
Family planning counseling	No charge (Deductible doesn't apply)
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge (Deductible doesn't apply)
Eye exams for refraction	No charge (Deductible doesn't apply)
Hearing exams	No charge (Deductible doesn't apply)
Chiropractic consultations and exams	$15 per visit (up to a total of 20 visits per calendar year)
Urgent care consultations and exams	$30 per visit (Deductible doesn't apply)
Physical, occupational, and speech therapy	$30 per visit after Deductible
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$250 per procedure after Deductible
Allergy injections (including allergy serum)	$5 per visit after Deductible
Most immunizations (including vaccines)	No charge (Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter after Deductible
Preventive X-rays, screenings, and laboratory tests as described in the "Benefits and Cost Sharing" section	No charge (Deductible doesn't apply)
MRI, most CT, and PET scans	$50 per procedure after Deductible
Health education:	
Covered individual health education counseling and programs	No charge (Deductible doesn't apply)
Covered group education programs	No charge (Deductible doesn't apply)
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$500 per day after Deductible
Emergency Health Coverage	**You Pay**
Emergency Department visits	$150 per visit after Deductible
Note: After you meet the Deductible, this Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).	
Ambulance Services	**You Pay**
Ambulance Services	$150 per trip after Deductible

Prescription Drug Coverage	You Pay
Most covered outpatient items in accord with our drug formulary guidelines:	
Generic items from a Plan Pharmacy	$10 for up to a 30-day supply, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply (Deductible doesn't apply)
Generic refills from our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply (Deductible doesn't apply)
Brand-name items from a Plan Pharmacy	$35 for up to a 30-day supply, $70 for a 31- to 60-day supply, or $105 for a 61- to 100-day supply (Deductible doesn't apply)
Brand-name refills from our mail-order service	$35 for up to a 30-day supply or $70 for a 31- to 100-day supply (Deductible doesn't apply)
Durable Medical Equipment	**You Pay**
The durable medical equipment for home use listed in the "Benefits and Cost Sharing" section in accord with our durable medical equipment formulary guidelines (most durable medical equipment is **not covered**) .	30% Coinsurance (Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization and intensive psychiatric treatment programs (up to 10 days per calendar year)	$500 per day after Deductible
Outpatient mental health evaluations and treatments:	
Up to a total of 10 individual and group visits per calendar year that include Services for mental health evaluation or treatment	$30 per individual visit (Deductible doesn't apply) $15 per group visit (Deductible doesn't apply)
Up to 30 additional group visits in the same calendar year that meet Medical Group criteria	$15 per visit (Deductible doesn't apply)
Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the "Benefits and Cost Sharing" section.	
Chemical Dependency Services	**You Pay**
Inpatient detoxification	$500 per day after Deductible
Individual outpatient chemical dependency consultations and treatment	$30 per visit (Deductible doesn't apply)
Group outpatient chemical dependency treatment	$5 per visit (Deductible doesn't apply)
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission after Deductible
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge (Deductible doesn't apply)
Other	**You Pay**
Skilled Nursing Facility care (up to 60 days per benefit period)	$50 per day after Deductible
Hospice care	No charge (Deductible doesn't apply)

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

Introduction

This *Individual Plan Membership Agreement and Disclosure Form and Evidence of Coverage (Membership Agreement and Evidence of Coverage)* describes the health care coverage of "Kaiser Permanente HIPAA Individual Deductible 30/1500 Plan." This *Membership Agreement and Evidence of Coverage,* the Rate Sheet which is incorporated into this *Membership Agreement and Evidence of Coverage* by reference, and any amendments, constitute the legally binding contract between Health Plan (Kaiser Foundation Health Plan, Inc.) and the Subscriber. For benefits provided under any other Health Plan program, refer to that plan's evidence of coverage.

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

The "Kaiser Permanente HIPAA Individual Plan" does not include dependent coverage, so each person in your family who is accepted for coverage must enroll as a Subscriber under his or her own *Membership Agreement and Evidence of Coverage* as described under "Who Is Eligible" and "How to Enroll" in the "Premiums, Eligibility, and Enrollment" section. Any references in this *Membership Agreement and Evidence of Coverage* to Dependents, Spouses, or children are not applicable to your coverage.

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

Note: The Health Plan Benefits and Coverage Matrix is located in the front of this *Membership Agreement and Evidence of Coverage.*

Term of this *Membership Agreement and Evidence of Coverage*, Renewal, and Amendment

Term of this *Membership Agreement and Evidence of Coverage*

This *Membership Agreement and Evidence of Coverage* becomes effective on the membership effective date in the Subscriber's acceptance letter and will remain in effect until one of the following occurs:

- The *Membership Agreement and Evidence of Coverage* is amended as described under "Amendment of *Membership Agreement and Evidence of Coverage*" in this "Introduction" section
- There are no longer any Members in your Family who are covered under this *Membership Agreement and Evidence of Coverage*

Note: Your membership may terminate even if this *Membership Agreement and Evidence of Coverage* remains in effect for other covered Members of your Family. The "Termination of Membership" section explains how membership may terminate.

Renewal

If you comply with all the terms of this *Membership Agreement and Evidence of Coverage*, we will automatically renew this *Membership Agreement and Evidence of Coverage* each year, effective on one of the following dates:

- **January 1** if the most recent effective date of the Subscriber's coverage is between January 1 and June 30
- **July 1** if the most recent effective date of the Subscriber's coverage is between July 1 and December 31

Terms of the *Membership Agreement and Evidence of Coverage* will remain the same when we renew it unless we have amended the *Membership Agreement and Evidence of Coverage* as described under "Amendment of *Membership Agreement and Evidence of Coverage*" in this "Term of this *Membership Agreement and Evidence of Coverage*, Renewal, and Amendment" section.

Amendment of *Membership Agreement and Evidence of Coverage*

In accord with "Notices" in the "Miscellaneous Provisions" section, **we may amend this *Membership Agreement and Evidence of Coverage* (including Premiums and benefits) at any time by sending written notice to the Subscriber at least 30 days before the effective date of the amendment**. The

amendment may become effective earlier than the end of the period for which you have already paid your Premiums, and it may require you to pay additional Premiums for that period. All amendments are deemed accepted by the Subscriber unless the Subscriber gives us written notice of non-acceptance within 30 days of the date of the notice, in which case this *Membership Agreement and Evidence of Coverage* terminates the day before the effective date of the amendment.

If we notified the Subscriber that we have not received all necessary governmental approvals related to this *Membership Agreement and Evidence of Coverage*, we may amend this *Membership Agreement and Evidence of Coverage* by giving written notice to the Subscriber after receiving all necessary governmental approval, in accord with "Notices" in the "Miscellaneous Provisions" section. Any such government-approved provisions go into effect on January 1, 2011 (unless the government requires a later effective date).

About Kaiser Permanente

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

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

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

Definitions

Some terms have special meaning in this *Membership Agreement and Evidence of Coverage*. When we use a term with special meaning in only one section of this *Membership Agreement and Evidence of Coverage*, we define it in that section. The terms in this "Definitions" section have special meaning when capitalized and used in any section of this *Membership Agreement and Evidence of Coverage*.

Charges: "Charges" means the following:

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

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

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

Cost Sharing: The amount you are required to pay for a covered Service, for example: the Deductible, Copayment, or Coinsurance.

Deductible: The amount you must pay in a calendar year for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that calendar year. Please refer to the "Benefits and Cost Sharing" section for the Services that are subject to the Deductible(s) and the Deductible amount(s).

Dependent: A Member who meets the eligibility requirements as a Dependent.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to himself or herself or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

Emergency Services: All of the following with respect to an Emergency Medical Condition:

- A medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post Stabilization Care and not Emergency Services)

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

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

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

Medical Group: The Permanente Medical Group, Inc., a for-profit professional corporation.

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

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

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

***Membership Agreement and Evidence of Coverage*:** This *Membership Agreement and Disclosure Form and Evidence of Coverage* document, which describes your Health Plan coverage. This *Membership Agreement and Evidence of Coverage*, the Rate Sheet which is incorporated into this *Membership Agreement and Evidence of Coverage* by reference, and any amendments, constitute the legally binding contract between Health Plan and the Subscriber.

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

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

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

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

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

Plan Facility: Any facility listed in the "Plan Facilities" section or in a Kaiser Permanente guidebook *(Your Guidebook)* for our Service Area, except that Plan

Facilities are subject to change at any time without notice. For the current locations of Plan Facilities, please call our Member Service Call Center.

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

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

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

Plan Physician: Any licensed physician who is 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, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that we designate as a Plan Provider.

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

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

Premiums: Periodic membership charges paid by or on behalf of each Member. Premiums are in addition to any Cost Sharing.

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Please refer to our website at **kp.org** for a directory of Primary Care Physicians, except that the directory is subject to change without notice. For the current list of physicians that are available as Primary Care Physicians, please call the personal physician selection department at the phone number listed in *Your Guidebook*.

Rate Sheet: The document that lists premiums for the "Kaiser Permanente HIPAA Individual Plan." The Premium for your coverage under this *Membership Agreement and Evidence of Coverage* is listed in the Rate Sheet included with the Subscriber's acceptance letter, unless the Rate Sheet has been amended as described under "Term and amendment of this *Membership Agreement and Evidence of Coverage*" in the "Introduction" section.

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

Service Area: The following counties are entirely inside our Service Area: Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, San Mateo, Solano, and Stanislaus. Portions of the following counties are also inside our Service Area, as indicated by the ZIP codes below for each county:

- Amador: 95640, 95669
- El Dorado: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762
- Fresno: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–30, 93737, 93741, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–79, 93786, 93790–94, 93844, 93888
- Kings: 93230, 93232, 93242, 93631, 93656
- Madera: 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720
- Mariposa: 93601, 93623, 93653
- Napa: 94503, 94508, 94515, 94558–59, 94562, 94567 (except that Knoxville is not in our Service Area), 94573–74, 94576, 94581, 94589–90, 94599, 95476
- Placer: 95602–04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95692, 95703, 95722, 95736, 95746–47, 95765
- Santa Clara: 94022–24, 94035, 94039–43, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–36, 95138–41, 95148, 95150–61, 95164, 95170, 95172–73, 95190–94, 95196

- Sonoma: 94515, 94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, 95492
- Sutter: 95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 95836–37
- Tulare: 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
- Yolo: 95605, 95607, 95612, 95616–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99
- Yuba: 95692, 95903, 95961

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

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

Services: Health care services or items ("health care" includes both physical health care and mental health care).

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Spouse: The Subscriber's legal husband or wife. For the purposes of this *Membership Agreement and Evidence of Coverage*, the term "Spouse" includes the Subscriber's same-sex spouse if the Subscriber and spouse are a couple who meet all of the requirements of Section 308(c) of the California Family Code, the Subscriber's registered domestic partner who meets all of the requirements of Sections 297 or 299.2 of the California Family Code, or the Subscriber's domestic partner as determined by Health Plan.

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and for whom we have received applicable Premiums.

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

Premiums, Eligibility, and Enrollment

Premiums

You must prepay the Premiums listed on the Rate Sheet, applicable to your coverage, for each month on or before the last day of the preceding month. **We may amend the Premiums listed on the Rate Sheet upon 30-days prior written notice, as described under "Term and amendment of this *Membership Agreement and Evidence of Coverage*" in the "Introduction" section.** Also, your Premiums may change as follows:

- When you move to a new rate area, any change in Premiums will take effect at the same time the change in your coverage becomes effective
- When the Subscriber progresses to a new age band, any change in Premiums will take effect upon renewal

Only Members for whom we have received the appropriate Premiums are entitled to coverage under this *Membership Agreement and Evidence of Coverage*, and then only for the period for which we have received payment.

If a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Health Plan or Plan Providers (or any of their activities), then upon 30-days prior written notice we may increase Premiums to include your share of the new or increased tax or charge. Your share is determined by dividing the number of

enrolled Members in your Family by the total number of Members enrolled in our Northern California Region.

Who Is Eligible

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

HIPAA eligibility

To enroll, you must meet the definition of an eligible individual under the Health Insurance Portability and Accountability Act (HIPAA). To be considered an eligible individual under HIPAA, you must meet all of the following requirements:

- Your most recent health care coverage must have been provided through your employment and under an employee welfare benefit plan, a church plan, or a government plan (all as defined by the Employee Retirement Income Security Act or "ERISA"). Your former employee benefit plan or issuer of health care coverage must provide you a certificate demonstrating the time periods you were insured or had health care coverage so that you can prove that you have the minimum amount of creditable coverage required. This is called a "certificate of creditable coverage." If you do not have or cannot obtain a certificate of creditable coverage, certification information may be provided by other means acceptable to us
- You cannot have any other health insurance coverage
- You cannot be eligible for coverage under an employee welfare benefit plan, Medicare, or Medi-Cal
- You have elected and exhausted any continuation coverage available under COBRA and Cal-COBRA
- You must have at least 18 months of creditable coverage and have not had a significant break between any of the periods of creditable coverage (please refer to "Creditable coverage" below for details)

Creditable coverage. "Creditable coverage" means health care coverage provided in connection with any of the following:

- A group health plan, including governmental or church plans
- Group or individual health insurance coverage
- Medicare
- Medicaid
- A military-sponsored health care program for members or certain former members of the uniformed services, and for their dependents
- A program of the Indian Health Service
- A state high risk pool
- The Federal Employees Health Benefits Program
- A public health plan, including any plan established or maintained by a state, the federal government, a foreign country, or any political subdivision of a state, the federal government, or a foreign country
- A health benefit plan provided for Peace Corps members
- A State Children's Health Insurance Program
- Any other form of health care coverage that meets the definition of creditable coverage under HIPAA

Coverage that consists solely of one or more of the following is **not** creditable coverage:

- Accident-only coverage
- Coverage for on-site medical clinics
- Disability income insurance
- Medicare supplemental coverage
- Limited-scope long term care, dental, or vision coverage
- Credit-only insurance
- Worker's compensation insurance
- Automobile medical payment insurance
- Coverage issued as a supplement to liability insurance
- Coverage which is payable with or without regard to fault that is legally required to be contained in any policy of liability insurance
- Any other insurance or coverage that does not meet the definition of creditable coverage under state or federal law

Consecutive periods of creditable coverage can be added together provided that a "significant break" between them has not occurred. A "significant break" occurs if 63 consecutive days pass between the date one period of creditable coverage ends and the earlier of either: (1) the date on which a substantially completed application for health care coverage was submitted to an issuer of a succeeding period of creditable coverage which became effective or (2) the first day of any employer-imposed waiting period or an affiliation period applicable to that succeeding coverage. If a significant break in creditable coverage has occurred, all periods of creditable coverage before that significant break are disallowed and you

cannot include those days in determining whether you have 18 months of creditable coverage.

Periods of an employer-imposed waiting period or affiliation period cannot be counted as periods of creditable coverage. If you have more than one source of creditable coverage on the same day, all the creditable coverage for that day counts as a single day of creditable coverage.

Service Area eligibility requirements

You must live or work in our Service Area at the time you enroll. The "Definitions" section describes our Service Area and how it may change.

If you live in or move to the service area of another Region after enrollment, you are not eligible for membership under this Northern California Region *Membership Agreement and Evidence of Coverage*:

- **Regions outside California.** If you move to the service area of a Region outside California, you may be able to apply for membership in that Region by contacting the member or customer service department there, but the plan, including coverage, premiums, and eligibility requirements, might not be the same. For the purposes of this eligibility rule, the service areas of the Regions outside California may change on January 1 of each year and are currently the District of Columbia and parts of Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington. For more information, please call our Member Service Call Center
- **Southern California Region's service area.** If you move to our Southern California Region's service area, we will transfer your membership to the individual plan in that Region that is most similar to this plan. All terms and conditions in your application for membership, including the Arbitration Agreement, will continue to apply. We will provide you with a Southern California Region membership agreement and evidence of coverage, the effective date of coverage, and a Kaiser Permanente ID card with a new medical record number on it. Please refer to the Rate Sheet for the premiums that apply in the Southern California Region. For more information, please call our Member Service Call Center

If you move anywhere else outside our Service Area after enrollment, you can continue your membership as long as you meet all other eligibility requirements. However, you must receive covered Services from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

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

Persons barred from enrolling

- You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause
- Persons who have had entitlement to receive Services through Health Plan terminated three times in any 12-month period for failure to pay individual (nongroup) plan premiums cannot enroll for 12 months after the second termination date. For the purposes of this paragraph, a termination does not count if we reinstated your entitlement to receive Services because you made full payment on or before the next scheduled payment due date following the one you missed

Members with Medicare

If you are (or become) eligible for Medicare, you are not eligible for coverage under the "Kaiser Permanente HIPAA Individual Plan."

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

How to Enroll

This plan does not include dependent coverage, so each person in your family who is accepted for coverage must enroll as a Subscriber under his or her own *Membership Agreement and Evidence of Coverage*.

To request enrollment in the Kaiser Permanente HIPAA Individual Plan, you must complete a Health Plan application. We must receive the application within 63 days after one of the following events:

- The date your health care coverage through an employee welfare benefit plan, a church plan, or a governmental plan ends
- The date your health care coverage through COBRA or Cal-COBRA ends, or any continuation coverage available under any state law after COBRA or Cal-COBRA coverage ends
- You received notice from us that we denied your application for Kaiser Permanente for Individuals and Families (KPIF) and you must have applied for KPIF enrollment within 63 days of the two events described immediately above

If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You will have 45 days to pay the bill. If you do not send us the Premium payment by the due date on the bill, you will not be enrolled in the Kaiser Permanente HIPAA Individual Plan.

Changing your benefit plan

If you choose the Deductible 30/1500 Plan, you cannot change to the Copayment 25 Plan later unless you request it within 30 days of your effective date of coverage under the Deductible 30/1500 Plan. If you choose the Copayment 25 Plan, you can change to the Deductible 30/1500 Plan at any time.

Effective date of coverage

If we approve your enrollment application, we will notify you of the date your coverage will begin.

How to Obtain Services

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

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

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

Routine Care

If you need the following Services, you should schedule an appointment:

- Preventive care (Services that protect against disease, promote health, or detect disease at its earliest stages before noticeable symptoms develop)
- Periodic follow-up care (regularly scheduled follow-up care, such as visits to monitor a chronic condition)
- Other care that is not Urgent Care

To make a non-urgent appointment, please refer to *Your Guidebook* for appointment telephone numbers, or go to our website at **kp.org** to request an appointment online.

Urgent Care

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 telephone number at a Plan Facility. Please refer to *Your Guidebook* for appointment and advice telephone numbers.

For information about Out-of-Area Urgent Care, please refer to "Urgent Care" in the "Emergency Services and Urgent Care" section.

Not Sure What Kind of Care You Need?

Sometimes it's difficult to know what kind of care you need, so we have licensed health care professionals available to assist you by phone 24 hours a day, seven days a week. Here are some of the ways they can help you:

- They can answer questions about a health concern, and instruct you on self-care at home if appropriate
- They can advise you about whether you should get medical care, and how and where to get care (for example, if you are not sure whether your condition is an Emergency Medical Condition, they can help you decide whether you need Emergency Services or Urgent Care, and how and where to get that care)
- They can tell you what to do if you need care and a Plan Medical Office is closed

You can reach one of these licensed health care professionals by calling the appointment or advice telephone number listed in *Your Guidebook*. When you call, a trained support person may ask you questions to help determine how to direct your call.

Your Personal Plan Physician

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

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

To learn how to select a personal Plan Physician, please refer to *Your Guidebook* or call our Member Service Call Center. You can find a directory of our Plan Physicians on our website at **kp.org**. For the current list of physicians that are available as Primary Care Physicians, please call the personal physician selection department at the phone number listed in *Your Guidebook*. You can change your personal Plan Physician for any reason.

Getting a Referral

Referrals to Plan Providers

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

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

Although a referral or prior authorization is not required to receive care from these providers, the provider may have to get prior authorization for certain Services in accord with "Medical Group authorization procedure for certain referrals" in this "Getting a Referral" section.

Medical Group authorization procedure for certain referrals

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

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

is Medically Necessary. For more information about our soft goods formulary, please refer to "Ostomy and Urological Supplies" in the "Benefits and Cost Sharing" section

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

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

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

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your physician will be informed of the scope of the authorized Services. If the Medical Group does not authorize all of the Services, Health Plan will send you a written decision and explanation within two business days after the decision is made. The letter will include information about your appeal rights, which are described in the "Dispute Resolution" section. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request.

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

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

Second Opinions

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

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

- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have concerns about the diagnosis or plan of care

You can either ask your Plan Physician to help you arrange for a second medical opinion, or you can make an appointment with another Plan Physician. If the Medical Group determines that there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, the Medical Group will authorize a referral to a Non–Plan Physician for a Medically Necessary second opinion.

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

Contracts with Plan Providers

How Plan Providers are paid

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

Financial liability

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

Breach of contract

We will give you written notice within a reasonable time if any contracted provider breaches a contract with us, or is not able to provide contracted Services, if you might be materially and adversely affected.

Termination of a Plan Provider's contract and completion of Services

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements. We will give you 60 days prior written notice (or as soon as reasonably possible) if a contracted provider group or hospital terminates a contract with us and you might be materially and adversely affected.

In addition, if you are currently receiving covered Services in one of the following cases from a Plan Hospital or a Plan Physician (or certain other providers) when our contract with the provider ends (for reasons other than medical disciplinary cause or criminal activity), you may be eligible for limited coverage of that terminated provider's Services:

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

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

- Your Health Plan coverage is in effect on the date you receive the Service
- You are receiving Services in one of the cases listed above from the terminated Plan Provider on the provider's termination date

- The provider agrees to our standard contractual terms and conditions, such as conditions pertaining to payment and to providing Services inside our Service Area
- The Services to be provided to you would be covered Services under this *Membership Agreement and Evidence of Coverage* if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from the termination date of the Plan Provider

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

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

Visiting Other Regions

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

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

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

Your ID Card

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

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

Getting Assistance

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

Member Services

Most Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Call Center representatives are available to assist you weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m. (except holidays) toll free at 1-800-464-4000 or 1-800-777-1370 (TTY for the deaf, hard of hearing, or speech impaired). For your convenience, you can also contact us through our website at **kp.org**.

Member Services representatives at our Plan Facilities and Member Service Call Center can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace your ID card. These representatives can also help you if you need to file a claim as described in the "Emergency Services and Urgent Care" section or with any issues as described in the "Dispute Resolution" section.

If you have questions about a bill or about how much you have paid toward your Deductible, or to get an estimate of Charges for Services that are subject to the Deductible, please call our Member Service Call Center weekdays from 8 a.m. to 7 p.m. toll free at 1-800-390-3507. You can also get an estimate of Charges for Services through our website at **kp.org**.

Interpreter services

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

Plan Facilities

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

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available from Plan Hospital Emergency Departments as described in *Your Guidebook* (please refer to *Your Guidebook* for Emergency Department locations in your area)
- Same-day Urgent Care appointments are available at many locations (please refer to *Your Guidebook* for Urgent Care locations in your area)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services Department (refer to *Your Guidebook* for locations in your area)

Plan Hospitals and Plan Medical Offices

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

Alameda

- Medical Offices: 2417 Central Ave.

Antioch

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

Campbell

- Medical Offices: 220 E. Hacienda Ave.

Clovis

- Medical Offices: 2071 Herndon Ave.

Daly City

- Medical Offices: 395 Hickey Blvd.

Davis

- Medical Offices: 1955 Cowell Blvd.

Elk Grove

- Medical Offices: 9201 Big Horn Blvd.

Fairfield

- Medical Offices: 1550 Gateway Blvd.

Folsom

- Medical Offices: 2155 Iron Point Rd.

Fremont

- Hospital and Medical Offices: 39400 Paseo Padre Pkwy.

Fresno

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

Gilroy

- Medical Offices: 7520 Arroyo Circle

Hayward

- Hospital and Medical Offices: 27400 Hesperian Blvd.

Lincoln

- Medical Offices: 1900 Dresden Dr.

Livermore

- Medical Offices: 3000 Las Positas Rd.

Manteca

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

Martinez

- Medical Offices: 200 Muir Rd.

Milpitas

- Medical Offices: 770 E. Calaveras Blvd.

Modesto

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

Mountain View

- Medical Offices: 555 Castro St.

Napa

- Medical Offices: 3285 Claremont Way

Novato

- Medical Offices: 97 San Marin Dr.

Oakhurst

- Medical Offices: 40595 Westlake Dr.

Oakland

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

Petaluma

- Medical Offices: 3900 Lakeville Hwy.

Pinole

- Medical Offices: 1301 Pinole Valley Rd.

Pleasanton

- Medical Offices: 7601 Stoneridge Dr.

Rancho Cordova

- Medical Offices: 10725 International Dr.

Redwood City

- Hospital and Medical Offices: 1150 Veterans Blvd.

Richmond

- Hospital and Medical Offices: 901 Nevin Ave.

Rohnert Park

- Medical Offices: 5900 State Farm Dr.

Roseville

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

Sacramento

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

San Bruno

- Medical Offices: 901 El Camino Real

San Francisco

- Hospital and Medical Offices: 2425 Geary Blvd.

San Jose

- Hospital and Medical Offices: 250 Hospital Pkwy.

San Rafael

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

Santa Clara

- Hospital and Medical Offices: 700 Lawrence Expwy.

Santa Rosa

- Hospital and Medical Offices: 401 Bicentennial Way

Selma

- Medical Offices: 2651 Highland Ave.

South San Francisco

- Hospital and Medical Offices: 1200 El Camino Real

Stockton

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

Tracy

- Medical Offices: 2185 W. Grant Line Rd.

Turlock

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

Union City

- Medical Offices: 3553 Whipple Rd.

Vacaville

- Hospital and Medical Offices: 1 Quality Dr.

Vallejo

- Hospital and Medical Offices: 975 Sereno Dr.

Walnut Creek

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

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

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

Your Guidebook to Kaiser Permanente Services (Your Guidebook)

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

Emergency Services and Urgent Care

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital Emergency Department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non–Plan Providers anywhere in the world as long as the Services would have been covered under the "Benefits and Cost Sharing" section (subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section) if you had received them from Plan Providers.

Emergency Services are available from Plan Hospital Emergency Departments 24 hours a day, seven days a week.

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that this condition is Stabilized. We cover Post-Stabilization Care from a Non–Plan Provider, including inpatient care at a Non–Plan Hospital, only if we provide prior authorization for the care or if otherwise required by applicable law ("prior authorization" means that we must approve the Services in advance).

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

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

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

Cost Sharing

The Cost Sharing for covered Emergency Services and Post-Stabilization Care is the Cost Sharing required for Services provided by Plan Providers as described in the "Benefits and Cost Sharing" section:

- Please refer to "Outpatient Care" for the Cost Sharing for Emergency Department visits
- The Cost Sharing for other covered Emergency Services and Post-Stabilization Care is the Cost Sharing that you would pay if the Services were not Emergency Services or Post-Stabilization Care. For example, if you are admitted as an inpatient to a Non–Plan Hospital for Post-Stabilization Care and we give

prior authorization for that care, your Cost Sharing would be the Cost Sharing listed under "Hospital Inpatient Care"

Services not covered under this "Emergency Services" section

Coverage for the following Services is described in other sections of this *Membership Agreement and Evidence of Coverage*:

- Follow-up care and other Services that are not Emergency Services or Post-Stabilization Care described in this "Emergency Services" section (refer to the "Benefits and Cost Sharing" section for coverage, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- Out-of-Area Urgent Care (refer to "Out-of-Area Urgent" care under "Urgent Care" in this "Emergency Services and Urgent Care" section)

Urgent Care

Inside the Service Area

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 telephone number at a Plan Facility. Please refer to *Your Guidebook* for appointment and advice telephone numbers.

Out-of-Area Urgent Care

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

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

You do not need prior authorization for Out-of-Area Urgent Care. We cover Out-of-Area Urgent Care you receive from Non–Plan Providers as long as the Services would have been covered under the "Benefits and Cost Sharing" section (subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section) if you had received them from Plan Providers.

Cost Sharing

The Cost Sharing for covered Urgent Care is the Cost Sharing required for Services provided by Plan Providers as described in the "Benefits and Cost Sharing" section:

- Please refer to "Outpatient Care" for the Cost Sharing for Urgent Care consultations and exams
- The Cost Sharing for other covered Urgent Care is the Cost Sharing that you would pay if the Services were not Urgent Care. For example, if the Urgent Care you receive includes an X-ray, your Cost Sharing for the X-ray would be the Cost Sharing for an X-ray listed under "Outpatient Imaging, Laboratory, and Special Procedures"

Services not covered under this "Urgent Care" section

Coverage for the following Services is described in other sections of this *Membership Agreement and Evidence of Coverage*:

- Follow-up care and other Services that are not Urgent Care or Out-of-Area Urgent Care described in this "Urgent Care" section (refer to the "Benefits and Cost Sharing" section for coverage, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider as described in this "Emergency Services and Urgent Care" section, or emergency ambulance Services described under "Ambulance Services" in the "Benefits and Cost Sharing" section, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us. Also, you may be required to pay and file a claim for any Services prescribed by a Non–Plan Provider as part of covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care even if you receive the Services from a Plan Provider, such as a Plan Pharmacy.

We will reduce any payment we make to you or the Non–Plan Provider by applicable Cost Sharing. Also, we will reduce our payment by any amounts paid or payable (or that in the absence of this plan would have been payable) for the Services under any insurance policy, or any other contract or coverage, or any government program except Medicaid. If payment under the other insurance or program is not made within a reasonable period of time, we will pay for covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care received from Non–Plan Providers if you:

- Assign all rights to payment to us and agree to cooperate with us in obtaining payment
- Allow us to obtain any relevant information from the other insurance or program
- Provide us with any information and assistance we need to obtain payment from the other insurance or program

How to file a claim

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

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

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

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

We will send you our written decision within 45 business days after we receive the claim unless we request additional information from you or the Non–Plan Provider. If we request additional information, we will send our written decision no later than 45 business days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in the letter, we will make our decision based on the information we have. If our decision is not fully in your favor, we will tell you the reasons and how to file a grievance as described under "Grievances" in the "Dispute Resolution" section.

Benefits and Cost Sharing

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

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
  - health care items and services for preventive care
  - health care items and services for diagnosis, assessment, or treatment
  - health education covered under "Health Education" in this "Benefits and Cost Sharing" section
  - other health care items and services
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except where specifically noted to the contrary in the sections listed below for the following Services:
  - emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- You receive the Services from Plan Providers inside our Service Area, except where specifically noted to the contrary in the sections listed below for the following Services:
  - authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
  - emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
  - hospice care as described under "Hospice Care" in this "Benefits and Cost Sharing" section

- The Medical Group has given prior authorization for the Services if required under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

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

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

Cost Sharing

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

- If you are receiving covered inpatient hospital or Skilled Nursing Facility Services on the effective date of this *Membership Agreement and Evidence of Coverage*, you pay the Cost Sharing in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Sharing in effect on the date you receive the Services
- For items ordered in advance, you pay the Cost Sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription
- If you receive more than one Service from a provider, or Services from more than one provider, you may be required to pay separate Cost Sharing amounts for each Service and each provider. For example, if you receive both preventive Services and non-preventive Services in the same visit, you may have to pay separate Cost Sharing for each Service received during that visit. Similarly, if your physician requests the assistance of another Plan Provider during a procedure, you may have to pay separate Cost Sharing amounts for the Services provided by each Plan Provider. If you have questions about Cost Sharing, please contact our Member Service Call Center
- In some cases, we may agree to bill you for your Cost Sharing amounts

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

Deductibles

In any calendar year, you must pay Charges for certain Services until you meet the Deductible. The Deductible is **$1,500** per calendar year.

After you meet the Deductible and for the remainder of the calendar year, you pay the applicable Copayment or Coinsurance subject to the limits described under "Annual out-of-pocket maximum" in this "Benefits and Cost Sharing" section.

Services that are subject to the Deductible. All covered Services are subject to the Deductible, except for those covered under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section, the "Chiropractic Services Amendment," and those that are listed as not subject to the Deductible in this "Benefits and Cost Sharing" section.

When Services are subject to a Deductible and you have not met the Deductible, you must pay Charges for the Services you are scheduled to receive when you check in for an appointment or procedure. Note: When we cover Services at "no charge" subject to the Deductible and you have not met your Deductible, you must pay Charges for the Services.

If you would like an estimate of the Charges for a Service before you schedule an appointment or procedure, please go to our website at **kp.org** or call our Member Service Call Center toll free at 1-800-390-3507. Note: If you pay a Deductible amount for a Service that

has a visit limit, the Services count toward reaching the limit.

After you receive the Services, we will compare the Charges for the Services subject to the Deductible that you actually received against what you paid when you checked in for an appointment or procedure. If you overpaid, we will send you a refund promptly. If you underpaid, we will bill you.

Keeping track of the Deductible. When you pay an amount toward your Deductible, we will give you a receipt and we will send you a statement. The statement will include the total amount you have paid toward your Deductible. You can also obtain a copy of this statement from our Member Service Call Center toll free at 1-800-390-3507. Any overpayments will be refunded to you promptly.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service (after you meet any applicable Deductible) is described in this "Benefits and Cost Sharing" section.

Annual out-of-pocket maximum

There is a limit to the total amount of Cost Sharing you must pay under this *Membership Agreement and Evidence of Coverage* in a calendar year for all of the covered Services listed below that you receive in the same calendar year. The limit is **$3,500** per calendar year.

Payments that count toward the maximum. Any amounts you pay for covered Services subject to the Deductible, as described under "Deductibles," apply toward the annual out-of-pocket maximum. Also, the Copayments and Coinsurance you pay for the following Services apply toward the annual out-of-pocket maximum:

- Administered drugs
- Ambulance Services
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)
- Diabetic testing supplies and equipment and insulin-administration devices
- Emergency Department visits
- Home health care
- Hospice care
- Hospital care, except that for mental health hospital care, the only care that counts is care for these mental health conditions:
  - Serious Emotional Disturbances of a child described under "Mental Health Services" in this "Benefits and Cost Sharing" section
  - 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
- Imaging, laboratory, and special procedures
- Intensive psychiatric treatment programs
- Outpatient surgery
- Prosthetic and orthotic devices
- Services performed during an office visit (including professional Services such as dialysis treatment, health education counseling and programs, and physical, occupational, and speech therapy). However, chemical dependency and chiropractic consultations and treatment do not count toward the maximum, and the only mental health Services that count toward the maximum are Services for these mental health conditions:
  - Serious Emotional Disturbances of a child described under "Mental Health Services" in this "Benefits and Cost Sharing" section
  - 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
- Skilled Nursing Facility care

Keeping track of the maximum. When you pay Cost Sharing that applies toward the annual out-of-pocket maximum, we will give you a receipt. We will also send you a statement summarizing the amounts you have paid toward your annual out-of-pocket maximum. You can also obtain a copy of this statement from our Member Service Call Center toll free at 1-800-390-3507.

Preventive Care Services

We cover a variety of preventive care Services, which are Services that do one or more of the following:

- Protect against disease, such as in the use of immunizations
- Promote health, such as counseling on tobacco use

- Detect disease in its earliest stages before noticeable symptoms develop, such as screening for breast cancer

This "Preventive Care Services" section explains Cost Sharing for some preventive care Services, but does not otherwise explain coverage. These preventive care Services are subject to all coverage requirements described in other parts of this "Benefits and Cost Sharing" section and all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. For example, we cover a preventive care Service that is an outpatient laboratory Service only if it is covered as described under the "Outpatient Imaging, Laboratory, and Special Procedures" section, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.

We cover at **no charge (not subject to the Deductible)** the preventive care Services listed on our "Health Reform Preventive Services List - CA regions." This list is subject to change at any time and is available from Member Services or on our website at **kp.org/formsandpubs**. If you receive any other covered Services during a preventive care visit, you will pay the applicable Cost Sharing for those Services.

The following are examples of preventive Services that are included in our "Health Reform Preventive Services List - CA Regions":

- Eye exams for refraction and preventive vision screenings
- Family planning counseling and programs
- Flexible sigmoidoscopies and colonoscopies
- Health education counseling and programs
- Hearing exams and screenings
- Immunizations (including vaccines) administered in a Plan Medical Office
- Preventive counseling, such as STD prevention counseling
- Routine preventive imaging services, including the following:
  - abdominal aortic aneurysm screening
  - bone density scans
  - mammograms
  - ultrasounds
- Routine physical maintenance exams, including well-woman exams
- Routine preventive retinal photography screenings
- Scheduled prenatal care exams and first postpartum follow-up consultation and exam
- Tuberculosis tests
- Well-child preventive care exams (0–23 months)
- The following laboratory tests:
  - routine preventive laboratory tests, such as cervical cancer screenings
  - cholesterol tests (lipid panel and profile)
  - diabetes screening (fasting blood glucose tests)
  - fecal occult blood tests
  - HIV tests
  - prostate specific antigen tests
  - certain sexually transmitted disease (STD) tests

If you receive both preventive and non-preventive Services in the same visit, you may have to pay separate Cost Sharing amounts for each Service received during that visit. For example, if you go in for a preventive exam, and your physician diagnoses you with an infection, you may have to pay separate Cost Sharing amounts for both the preventive exam and for the Services performed to diagnose a condition.

Outpatient Care

We cover the following outpatient care subject to the Cost Sharing indicated:

- Most primary and specialty care consultations and exams: **a $30 Copayment per visit (not subject to the Deductible)**
- Routine physical maintenance exams, including well-woman exams: **no charge (not subject to the Deductible)**
- Well-child preventive exams for Members through age 23 months: **no charge (not subject to the Deductible)**
- Family planning counseling, or to obtain internally implanted time-release contraceptives or intrauterine devices (IUDs) prescribed in accord with our drug formulary guidelines: **no charge (not subject to the Deductible)**
- After confirmation of pregnancy, the normal series of regularly scheduled preventive care prenatal care exams and the first postpartum follow-up consultation and exam: **no charge (not subject to the Deductible)**
- Alcohol and substance abuse interventions: **no charge (not subject to the Deductible)**

- Developmental screenings to diagnose and assess potential developmental delays: **no charge (not subject to the Deductible)**
- Immunizations (including vaccines) administered to you in a Plan Medical Office: **no charge (not subject to the Deductible)**
- Flexible sigmoidoscopies: **no charge (not subject to the Deductible)**
- Colonoscopies: **no charge (not subject to the Deductible)**
- Allergy injections (including allergy serum): **a $5 Copayment per visit subject to the Deductible**
- Outpatient surgery: **a $250 Copayment per procedure subject to the Deductible** if it is provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. Any other outpatient surgery is covered at **a $30 Copayment per procedure (not subject to the Deductible)**
- Outpatient procedures (other than surgery): **a $250 Copayment per procedure subject to the Deductible** if a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. All outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above are covered **at the Cost Sharing that would otherwise apply for the procedure** in this "Benefits and Cost Sharing" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Special Procedures")
- Voluntary termination of pregnancy: **a $30 Copayment per procedure subject to the Deductible**
- Physical, occupational, and speech therapy: **a $30 Copayment per visit subject to the Deductible**
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program: **a $30 Copayment per day subject to the Deductible**
- Urgent Care consultations and exams: **a $30 Copayment per visit (not subject to the Deductible)**
- Emergency Department visits: **a $150 Copayment per visit subject to the Deductible**. After you meet the Deductible, the Emergency Department Copayment does not apply if you are admitted directly to the hospital as an inpatient for covered Services, or if you are admitted for observation and are then admitted directly to the hospital as an inpatient for covered Services (for inpatient care, please refer to "Hospital Inpatient Care" in this "Benefits and Cost Sharing" section). However, after you meet the Deductible, the Emergency Department Copayment does apply if you are admitted for observation but are not admitted as an inpatient
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician: **no charge (not subject to the Deductible)**
- Acupuncture Services provided for the treatment of nausea or as part of a multidisciplinary pain management program for the treatment of chronic pain: **a $30 Copayment per visit (not subject to the Deductible)**
- Blood, blood products, and their administration: **no charge subject to the Deductible**
- Administered drugs (drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials) prescribed in accord with our drug formulary guidelines, if administration or observation by medical personnel is required and they are administered to you in a Plan Medical Office or during home visits: **no charge (not subject to the Deductible)**
- Some types of outpatient consultations and exams may be available as group appointments, which we cover at **a $15 Copayment per visit (not subject to the Deductible)**

Services not covered under this "Outpatient Care" section

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

- Bariatric Surgery
- Chemical Dependency Services
- Dental and Orthodontic Services
- Dialysis Care
- Durable Medical Equipment for Home Use
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Mental Health Services

- Ostomy and Urological Supplies
- Outpatient Imaging, Laboratory, and Special Procedures
- Outpatient Prescription Drugs, Supplies, and Supplements
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Transplant Services
- Vision Services

Hospital Inpatient Care

We cover the following inpatient Services at **a $500 Copayment per day subject to the Deductible** in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals inside our Service Area:

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

Services not covered under this "Hospital Inpatient Care" section

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

- Bariatric Surgery
- Chemical Dependency Services
- Dental and Orthodontic Services
- Dialysis Care
- Hospice Care
- Mental Health Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Skilled Nursing Facility Care
- Transplant Services

Ambulance Services

Emergency

We cover at **a $150 Copayment per trip subject to the Deductible** Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) if one of the following is true:

- You reasonably believe that you have an Emergency Medical Condition and you reasonably believe that your condition requires the clinical support of ambulance transport services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

If you receive emergency ambulance Services that are not ordered by a Plan Provider, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us. Please refer to "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section for how to file a claim for reimbursement.

Nonemergency

Inside our Service Area, we cover nonemergency ambulance and psychiatric transport van Services at **a $150 Copayment per trip subject to the Deductible** if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to or from covered Services.

Ambulance Services exclusion

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

Bariatric Surgery

We cover hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, special procedures, and Plan Physician Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

- You complete the Medical Group–approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success
- A Plan Physician who is a specialist in bariatric care determines that the surgery is Medically Necessary

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

If you live 50 miles or more from the facility to which you are referred for a covered bariatric surgery, we will reimburse you for certain travel and lodging expenses if you receive prior written authorization from the Medical Group and send us adequate documentation including receipts. We will not, however, reimburse you for any travel or lodging expenses if you were offered a referral to a facility that is less than 50 miles from your home. We will reimburse authorized and documented travel and lodging expenses as follows:

- Transportation for you to and from the facility up to $130 per round trip for a maximum of three trips (one pre-surgical visit, the surgery, and one follow-up visit), including any trips for which we provided reimbursement under any other evidence of coverage
- Transportation for one companion to and from the facility up to $130 per round trip for a maximum of two trips (the surgery and one follow-up visit), including any trips for which we provided reimbursement under any other evidence of coverage
- One hotel room, double-occupancy, for you and one companion not to exceed $100 per day for the pre-surgical visit and the follow-up visit, up to two days per trip, including any hotel accommodations for which we provided reimbursement under any other evidence of coverage
- Hotel accommodations for one companion not to exceed $100 per day for the duration of your surgery stay, up to four days, including any hotel accommodations for which we provided reimbursement under any other evidence of coverage

Services not covered under this "Bariatric Surgery" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Chemical Dependency Services

Inpatient detoxification

We cover hospitalization at **a $500 Copayment per day subject to the Deductible** in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Outpatient chemical dependency care

We cover the following Services for treatment of chemical dependency:

- Day-treatment programs
- Intensive outpatient programs
- Individual and group chemical dependency counseling
- Outpatient chemical dependency consultation and treatment for withdrawal symptoms

You pay the following for these covered Services:

- Individual chemical dependency consultations and treatment: **a $30 Copayment per visit (not subject to the Deductible)**

- Group chemical dependency treatments: **a $5 Copayment per visit (not subject to the Deductible)**

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

Transitional residential recovery Services

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

Services not covered under this "Chemical Dependency Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Chemical dependency Services exclusion

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

Dental and Orthodontic Services

We do not cover most dental and orthodontic Services, but we do cover some dental and orthodontic Services as described in this "Dental and Orthodontic Services" section.

Dental Services for radiation treatment

We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck at **a $30 Copayment per visit (not subject to the Deductible)** if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental anesthesia

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

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

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

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

Dental and orthodontic Services for cleft palate

We cover dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic Services, if they meet all of the following requirements:

- The Services are an integral part of a reconstructive surgery for cleft palate that we are covering under "Reconstructive Surgery" in this "Benefits and Cost Sharing" section
- A Plan Provider provides the Services or the Medical Group authorizes a referral to a Non-Plan Provider who is a dentist or orthodontist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)

You pay the following for these dental and orthodontic Services for cleft palate:

- Consultations and exams: **a $30 Copayment per visit (not subject to the Deductible)**
- Hospital inpatient care: **a $500 Copayment per day subject to the Deductible**
- Outpatient surgery: **a $250 Copayment per procedure subject to the Deductible** if it is provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.

Any other outpatient surgery: **a $30 Copayment per procedure (not subject to the Deductible)**

- Outpatient procedures (other than surgery): **a $250 Copayment per procedure subject to the Deductible** if a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. All outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above are covered **at the Cost Sharing that would otherwise apply for the procedure** in this "Benefits and Cost Sharing" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Special Procedures")

Services not covered under this "Dental and Orthodontic Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Outpatient imaging, laboratory, and special procedures (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient administered drugs (refer to "Outpatient Care"), except that we cover outpatient administered drugs under "Dental anesthesia" in this "Dental and Orthodontic Services" section
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Dialysis Care

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

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

After you receive appropriate training at a dialysis facility we designate, we also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside our Service Area at **no charge subject to the Deductible**. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

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

- Inpatient dialysis care: **a $500 Copayment per day subject to the Deductible**
- One routine office consultation or exam per month with the multidisciplinary nephrology team: **no charge (not subject to the Deductible)**
- All other consultations or exams: **a $30 Copayment per visit (not subject to the Deductible)**
- Hemodialysis treatment at a Plan Facility: **a $30 Copayment per visit subject to the Deductible**

Services not covered under this "Dialysis Care" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Durable medical equipment for home use (refer to "Durable Medical Equipment for Home Use")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Dialysis Care exclusions

- Comfort, convenience, or luxury equipment, supplies and features
- Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

Durable Medical Equipment for Home Use

Inside our Service Area, we cover the durable medical equipment specified in this "Durable Medical Equipment for Home Use" section for use in your home (or another location used as your home) in accord with our durable medical equipment formulary guidelines. Durable medical equipment for home use is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. Covered durable medical equipment (including repair or replacement of covered equipment, unless due to loss or misuse) is provided at **30% Coinsurance (not subject to the Deductible)**. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.

Inside our Service Area, we cover the following durable medical equipment for use in your home (or another location used as your home):

- For diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other drugs)
- Standard curved handle or quad cane and replacement supplies
- Standard or forearm crutches and replacement supplies
- Dry pressure pad for a mattress
- Nebulizer and supplies
- Peak flow meters
- IV pole
- Tracheostomy tube and supplies
- Enteral pump and supplies
- Bone stimulator
- Cervical traction (over door)
- Phototherapy blankets for treatment of jaundice in newborns

Outside the Service Area

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

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

About our durable medical equipment formulary

Our durable medical equipment formulary includes the list of durable medical equipment that has been approved by our Durable Medical Equipment Formulary Executive Committee for our Members. Our durable medical equipment formulary was developed by a multidisciplinary clinical and operational work group with review and input from Plan Physicians and medical professionals with durable medical equipment expertise (for example: physical, respiratory, and enterostomal therapists and home health). A multidisciplinary Durable Medical Equipment Formulary Executive Committee is responsible for reviewing and revising the durable medical equipment formulary. Our durable medical equipment formulary is periodically updated to keep pace with changes in medical technology and clinical practice.

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

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

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Durable medical equipment for home use exclusion

- Comfort, convenience, or luxury equipment or features

Health Education

We cover a variety of health education counseling, programs, and materials that your personal Plan Physician or other Plan Providers provide during a visit covered under another part of this "Benefits and Cost Sharing" section.

We also cover a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for tobacco cessation, stress management, and chronic conditions (such as diabetes and asthma). Kaiser Permanente also offers health education counseling, programs, and materials that are not covered, and you may be required to pay a fee.

For more information about our health education counseling, programs, and materials, please contact your local Health Education Department or our Member Service Call Center, refer to *Your Guidebook*, or go to our website at **kp.org**.

You pay the following for these covered Services:

- Group health education programs: **no charge (not subject to the Deductible)**
- Individual counseling and programs when the visit is solely for health education: **no charge (not subject to the Deductible)**
- Health education provided during an outpatient consultation or exam covered in another part of this "Benefits and Cost Sharing" section: **no additional Cost Sharing beyond the Cost Sharing required in that other part of this "Benefits and Cost Sharing" section**
- Covered health education materials: **no charge (not subject to the Deductible)**

Hearing Services

We cover the following:

- Routine preventive hearing screenings: **no charge (not subject to the Deductible)**
- Hearing exams to determine the need for hearing correction: **no charge (not subject to the Deductible)**

Services not covered under this "Hearing Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Hearing Services exclusions

- Hearing aids and tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. We cover home health care at **no charge (not subject to the Deductible)** only if all of the following are true:

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

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

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

Note: If a visit by a nurse, medical social worker, or physical, occupational, or speech therapist lasts longer than two hours, then each additional increment of two

hours counts as a separate visit. If a visit by a home health aide lasts longer than four hours, then each additional increment of four hours counts as a separate visit. For example, if a nurse comes to your home for three hours and then leaves, that counts as two visits. Also, each person providing Services counts toward these visit limits. For example, if a home health aide and a nurse are both at your home during the same two hours, that counts as two visits.

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

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

Home health care exclusions

- Care of a type that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. This care is excluded even if we would cover the care if it were provided by a qualified medical professional in a hospital or a Skilled Nursing Facility
- Care in the home if the home is not a safe and effective treatment setting

Hospice Care

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

We cover the hospice Services listed below at **no charge (not subject to the Deductible)** only if all of the following requirements are met:

- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside our Service Area or inside California but within 15 miles or 30 minutes from our Service Area (including a friend's or relative's home even if you live there temporarily)
- The Services are provided by a licensed hospice agency that is a Plan Provider
- The Services are necessary for the palliation and management of your terminal illness and related conditions

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

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

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when the Services are for the diagnosis or treatment of Mental Disorders.

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

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

- "Severe Mental Illness" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.
- A "Serious Emotional Disturbance" of a child under age 18 means mental disorders as identified in the *DSM*, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:
  - as a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either (1) the child is at risk of removal from the home or has already been removed from the home, or (2) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
  - the child displays psychotic features, or risk of suicide or violence due to a mental disorder
  - the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

Any outpatient visit limits specified under "Outpatient mental health Services" and inpatient day limits specified under "Calendar-year day limit for inpatient psychiatric hospitalization and intensive psychiatric treatment programs" do not apply to Severe Mental Illness of a person of any age and the Serious Emotional Disturbance of a child. For all other mental health conditions, we cover evaluation and treatment only when a Plan Physician or other Plan Provider who is a license health care professional acting within the scope of his or her license believes the condition will significantly improve with relatively short-term therapy.

Outpatient mental health Services

We cover the following Services when provided by Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license:

- Up to a combined visit limit of 10 individual and group visits per Member calendar year that include Services for mental health evaluation and treatment as described in this "Outpatient mental health Services" section. Members who have exhausted the 10-visit limitation and who meet Medical Group criteria may receive up to 30 additional group visits in the same calendar year
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient Services for the purpose of monitoring drug therapy

You pay the following for these covered Services:

- Individual mental health evaluation and treatment: **a $30 Copayment per visit (not subject to the Deductible)**
- Group mental health treatment: **a $15 Copayment per visit (not subject to the Deductible)**

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

Inpatient psychiatric hospitalization and intensive psychiatric treatment programs

Inpatient psychiatric hospitalization. Subject to the day limit described under "Calendar-year day limit for inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in this "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" section, we cover inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and Services of Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license. We cover these Services at **a $500 Copayment per day subject to the Deductible**.

Intensive psychiatric treatment programs. Subject to the day limit described under "Calendar-year day limit for inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in this "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" section, we cover at **no charge subject to the Deductible** the following intensive psychiatric treatment programs at a Plan Facility:

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

Calendar-year day limit for inpatient psychiatric hospitalization and intensive psychiatric treatment programs. There is a combined day limit of 10 days per Member per calendar year for psychiatric care described under "Inpatient psychiatric hospitalization" and "Intensive psychiatric treatment programs" in this "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" section, except that the day limit does not apply to psychiatric care for the treatment of Severe Mental Illnesses and Serious Emotional Disturbance of a child under age 18. The number of days is determined by adding up the number of days of inpatient psychiatric hospitalization and intensive psychiatric treatment program Services we cover in a calendar year that are subject to the limit as follows:

- Each day of inpatient psychiatric hospitalization counts as one day
- Two days of hospital-based intensive outpatient care (partial hospitalization) count as one day
- Three days of treatment in an intensive outpatient psychiatric treatment program count as one day
- Each day of treatment in a crisis residential program counts as one day
- Two psychiatric observation treatment periods of 23 consecutive hours or less count as one day

If you reach the day limit, we will not cover any more inpatient psychiatric hospitalization or intensive psychiatric treatment program Services in that calendar year if they are subject to the day limit.

Services not covered under this "Mental Health Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Ostomy and Urological Supplies

Inside our Service Area, we cover ostomy and urological supplies prescribed in accord with our soft goods formulary guidelines at **no charge (not subject to the Deductible)**. We select the vendor, and coverage is limited to the standard supply that adequately meets your medical needs.

About our soft goods formulary

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

Our formulary guidelines allow you to obtain nonformulary ostomy and urological supplies (those not listed on our soft goods formulary for your condition) if they would otherwise be covered and the Medical Group determines that they are Medically Necessary as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

Ostomy and urological supplies exclusion

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Special Procedures

We cover the following Services at the Cost Sharing indicated only when prescribed as part of care covered under other headings in this "Benefits and Cost Sharing" section:

- Most diagnostic and therapeutic imaging, such as X-rays, mammograms, and ultrasounds: **a $10 Copayment per encounter subject to the Deductible** except that certain imaging procedures are covered at **a $250 Copayment per procedure subject to the Deductible** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort
- Preventive imaging, such as preventive mammograms, aortic aneurysm screenings, and bone density screenings: **no charge (not subject to the Deductible)**
- MRI, most CT, and PET scans: **a $50 Copayment per procedure subject to the Deductible**
- Nuclear medicine: **a $10 Copayment per encounter subject to the Deductible**
- Laboratory tests (including tests for specific genetic disorders for which genetic counseling is available):
  - laboratory tests to monitor the effectiveness of dialysis: **no charge subject to the Deductible**
  - fecal occult blood tests: **no charge (not subject to the Deductible)**
  - preventive laboratory tests and screenings, including cervical cancer screenings, prostate specific antigen tests, cholesterol tests (lipid panel and profile), diabetes screening (fasting blood glucose tests), certain sexually transmitted disease (STD) tests, and HIV tests: **no charge (not subject to the Deductible)** when they are ordered as a preventive screening test (and not to diagnose or treat an existing illness, injury, or condition that has already been diagnosed or for which you have symptoms)
  - all other laboratory tests: **a $10 Copayment per encounter subject to the Deductible**
- Routine preventive retinal photography screenings: **no charge (not subject to the Deductible)**
- All other diagnostic procedures provided by Plan Providers who are not physicians (such as EKGs and EEGs): **a $10 Copayment per encounter subject to the Deductible** except that certain diagnostic procedures are covered at **a $250 Copayment per procedure subject to the Deductible** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort
- Radiation therapy: **no charge subject to the Deductible**
- Ultraviolet light treatments: **no charge (not subject to the Deductible)**

Outpatient Prescription Drugs, Supplies, and Supplements

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

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

How to obtain covered items

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

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

Refills. You may be able to order refills from a Plan Pharmacy, our mail-order service, or through our website at **kp.org/rxrefill**. A Plan Pharmacy or *Your Guidebook* can give you more information about obtaining refills,

including the options available to you for obtaining refills. For example, a few Plan Pharmacies don't dispense refills and not all drugs can be mailed through our mail-order service. Please check with your local Plan Pharmacy if you have a question about whether or not your prescription can be mailed or obtained from a Plan Pharmacy. Items available through our mail-order service are subject to change at any time without notice.

Outpatient drugs, supplies, and supplements

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

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

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

- Generic items:
  - **a $10 Copayment** for up to a 30-day supply, **a $20 Copayment** for a 31- to 60-day supply, or **a $30 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
  - **a $10 Copayment** for up to a 30-day supply or **a $20 Copayment** for a 31- to 100-day supply through our mail-order service
  - drugs prescribed for the treatment of sexual dysfunction disorders: **50% Coinsurance** for up to a 100-day supply at a Plan Pharmacy or through our mail-order service
- Brand-name items and compounded products:
  - **a $35 Copayment** for up to a 30-day supply, **a $70 Copayment** for a 31- to 60-day supply, or **a $105 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
  - **a $35 Copayment** for up to a 30-day supply or **a $70 Copayment** for a 31- to 100-day supply through our mail-order service
  - drugs prescribed for the treatment of sexual dysfunction disorders: **50% Coinsurance** for up to a 100-day supply at a Plan Pharmacy or through our mail-order service
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria) and elemental dietary enteral formula when used as a primary therapy for regional enteritis: **no charge** for up to a 30-day supply
- Emergency contraceptive pills: **no charge**
- Hematopoietic agents for dialysis: **no charge** for up to a 30-day supply
- Continuity drugs (if this *Membership Agreement and Evidence of Coverage* is amended to exclude a drug that we have been covering and providing to you under this *Membership Agreement and Evidence of Coverage*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration): **50% Coinsurance** for up to a 30-day supply in a 30-day period

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

Certain intravenous drugs, supplies, and supplements

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

Diabetes urine-testing supplies and insulin-administration devices

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

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

Day supply limit

The prescribing physician or dentist determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, Plan Physicians determine the amount of an item that constitutes a Medically Necessary 30-, 60-, or 100-day supply for you. Upon payment of the Cost Sharing specified in this "Outpatient Prescription Drugs, Supplies, and

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

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

About our drug formulary

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

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

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

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Outpatient prescription drugs, supplies, and supplements exclusions

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

Prosthetic and Orthotic Devices

We do not cover most prosthetic and orthotic devices, but we do cover devices as described in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select

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 cover a replacement device, then you pay the Cost Sharing that you would pay for obtaining that device.

Internally implanted devices

We cover prosthetic and orthotic devices, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if they are implanted during a surgery that we are covering under another section of this "Benefits and Cost Sharing" section. We cover these devices at **no charge subject to the Deductible**.

External devices

We cover the following external prosthetic and orthotic devices at **no charge (not subject to the Deductible)**:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres required to hold a prosthesis every 12 months
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

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

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Contact lenses to treat aniridia or aphakia (refer to "Vision Services")

Prosthetic and orthotic devices exclusions

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Except as otherwise described above in this "Prosthetic and Orthotic Devices" section, nonrigid supplies, such as elastic stockings and wigs
- Comfort, convenience, or luxury equipment or features
- Shoes or arch supports, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications

Reconstructive Surgery

We cover the following reconstructive surgery Services:

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

You pay the following for covered reconstructive surgery Services:

- Consultations and exams: **a $30 Copayment per visit (not subject to the Deductible)**
- Outpatient surgery: **a $250 Copayment per procedure subject to the Deductible** if it is provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. Any other outpatient surgery: **a $30 Copayment per procedure (not subject to the Deductible)**
- Hospital inpatient care (including room and board, drugs, and Plan Physician Services): **a $500 Copayment per day subject to the Deductible**

Services not covered under this "Reconstructive Surgery" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Dental and orthodontic Services that are an integral part of reconstructive surgery for cleft palate (refer to "Dental and Orthodontic Services")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

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

Reconstructive surgery exclusions

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

Services Associated with Clinical Trials

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

- You are diagnosed with cancer
- You are accepted into a phase I, II, III, or IV clinical trial for cancer
- Your treating Plan Physician, or your treating Non–Plan Physician if the Medical Group authorizes a written referral to the Non–Plan Physician for treatment of cancer (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section), recommends participation in the clinical trial after determining that it has a meaningful potential to benefit you
- The Services would be covered under this *Membership Agreement and Evidence of Coverage* if they were not provided in connection with a clinical trial
- The clinical trial has a therapeutic intent, and its end points are not defined exclusively to test toxicity
- The clinical trial involves a drug that is exempt under federal regulations from a new drug application, or the clinical trial is approved by: one of the National Institutes of Health, the federal Food and Drug Administration (in the form of an investigational new drug application), the U.S. Department of Defense, or the U.S. Department of Veterans Affairs

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

Services associated with clinical trials exclusions

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

Skilled Nursing Facility Care

Inside our Service Area, we cover at **a $50 Copayment per day subject to the Deductible** up to 60 days per benefit period (including any days we covered under any other evidence of coverage) of skilled inpatient Services in a Plan Skilled Nursing Facility. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

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

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment in accord with our durable medical equipment formulary if Skilled Nursing Facilities ordinarily furnish the equipment
- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Blood, blood products, and their administration
- Medical supplies
- Physical, occupational, and speech therapy
- Respiratory therapy

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

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Transplant Services

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

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

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

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

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

Services not covered under this "Transplant Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

Vision Services

We cover the following:

- Routine preventive vision screenings: **no charge (not subject to the Deductible)**
- Eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses: **no charge (not subject to the Deductible)**
- Up to two Medically Necessary contact lenses, fitting, and dispensing per eye every 12 months (including lenses we covered under any other evidence of coverage) to treat aniridia (missing iris): **no charge (not subject to the Deductible)**
- Up to six Medically Necessary aphakic contact lenses, fitting, and dispensing per eye per calendar year (including lenses we covered under any other evidence of coverage) to treat aphakia (absence of the crystalline lens of the eye) for Members through age 9: **no charge (not subject to the Deductible)**

Services not covered under this "Vision Services" section

- Services related to the eye or vision other than Services covered under this "Vision Services" section

Vision Services exclusions

- Industrial frames
- Services for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism
- Eyeglass lenses and frames
- Contact lenses, including fitting and dispensing (except for contact lenses to treat aphakia or aniridia as described under this "Vision Services" section)
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low vision devices

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this *Membership Agreement and Evidence of Coverage* regardless of whether the services are within the scope of a provider's license or certificate. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the "Benefits and Cost Sharing" section.

Acupuncture Services

Acupuncture Services and the Services of an acupuncturist except for Services covered under "Outpatient Care" in the "Benefits and Cost Sharing" section.

Artificial insemination and conception by artificial means

All Services related to artificial insemination and conception by artificial means, such as: ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and Services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

Certain exams and Services

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

Chiropractic Services

Chiropractic Services and the Services of a chiropractor, except as described in the "Chiropractic Services Amendment."

Cosmetic Services

Services that are intended primarily to change or maintain your appearance, except that this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "Benefits and Cost Sharing" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "Benefits and Cost Sharing" section: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after a mastectomy and prostheses to replace all or part of an external facial body part

Custodial care

Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, Skilled Nursing Facility, or inpatient hospital care.

Dental and orthodontic Services

Dental and orthodontic Services such as X-rays, appliances, implants, Services provided by dentists or orthodontists, dental Services following accidental injury to teeth, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment.

This exclusion does not apply to Services covered under "Dental and Orthodontic Services" in the "Benefits and Cost Sharing" section.

Disposable supplies

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

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

Experimental or investigational Services

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

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

This exclusion does not apply to any of the following:

- Experimental or investigational Services when an investigational application has been filed with the

federal Food and Drug Administration (FDA) and the manufacturer or other source makes the Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol

- Services covered under "Services Associated with Clinical Trials" in the "Benefits and Cost Sharing" section

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

Hair loss or growth treatment

Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Infertility Services

Services related to the diagnosis and treatment of infertility.

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Durable Medical Equipment," "Home Health Care," and "Hospice Care" in the "Benefits and Cost Sharing" section.

Items and services that are not health care items and services

For example, we do not cover:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services that increase academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy

Massage therapy

Oral nutrition

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

This exclusion does not apply to any of the following:

- Amino acid–modified products and elemental dietary enteral formula covered under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section
- Enteral formula covered under "Prosthetic and Orthotic Devices" in the "Benefits and Cost Sharing" section

Residential care

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

Routine foot care items and services

Routine foot care items and services that are not Medically Necessary.

Services not approved by the federal Food and Drug Administration

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

This exclusion does not apply to any of the following:

- Services covered under the "Emergency Services and Urgent Care" section that you receive outside the U.S.
- Experimental or investigational Services when an investigational application has been filed with the FDA and the manufacturer or other source makes the

Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol

- Services covered under "Services Associated with Clinical Trials" in the "Benefits and Cost Sharing" section

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

Services performed by unlicensed people

Services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the Member's condition does not require that the services be provided by a licensed health care provider.

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services we would otherwise cover to treat complications of the noncovered Service. For example, if you have a noncovered cosmetic surgery, we would not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and we would cover any Services that we would otherwise cover to treat that complication.

Surrogacy

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

Transgender surgery

Travel and lodging expenses

Travel and lodging expenses, except that in some situations if the Medical Group refers you to a Non–Plan Provider as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines **not subject to the Deductible**. Our travel and lodging guidelines are available from our Member Service Call Center.

This exclusion does not apply to reimbursement for travel and lodging expenses provided under "Bariatric Surgery" in the "Benefits and Cost Sharing" section.

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services under this *Membership Agreement and Evidence of Coverage*, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor disputes. Under these circumstances, if you have an Emergency Medical Condition, call 911 or go to the nearest hospital as described under "Emergency Services" in the "Emergency Services and Urgent Care" section, and we will provide coverage and reimbursement as described in that section.

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

Coordination of Benefits

If you have Medicare coverage, we will coordinate benefits with your Medicare coverage under Medicare rules. Medicare rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." You must give us any information we request to help us coordinate benefits. Please call our Member Service Call Center to find out which Medicare rules apply to your situation, and how payment will be handled.

Note: If you are (or become) eligible for Medicare, you are not eligible for coverage under the "Kaiser Permanente HIPAA Individual Plan."

Reductions

Employer responsibility

For any Services that the law requires an employer to provide, we will not pay the employer, and when we

cover any such Services we may recover the value of the Services from the employer.

Government agency responsibility

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

Injuries or illnesses alleged to be caused by third parties

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

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

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

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

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

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

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

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

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

Medicare benefits

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

Surrogacy arrangements

If you enter into a surrogacy arrangement, you must pay us Charges for covered Services you receive related to conception, pregnancy, or delivery in connection with that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed the compensation you are entitled to receive under the surrogacy arrangement. A surrogacy arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. Note: This "Surrogacy arrangements" section does not affect your obligation to pay Cost Sharing for these Services, but we will credit

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

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

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

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

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

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

U.S. Department of Veterans Affairs

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

Workers' compensation or employer's liability benefits

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

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

Dispute Resolution

Grievances

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

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

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

in the "Benefits and Cost Sharing" section and you want to appeal our decision

- You are dissatisfied with how long it took to get Services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility
- Your membership was terminated retroactively for a reason other than nonpayment of Premiums or contributions toward the cost of coverage
- We denied your membership application

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

- If we did not decide fully in your favor on a claim for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits and Cost Sharing" section and you want to appeal our decision, you can submit your grievance in one of the following ways:
  - to the Claims Department at the following address:
    Kaiser Foundation Health Plan, Inc.
    Special Services Unit
    P.O. Box 23280
    Oakland, CA 94623
  - by calling our Member Service Call Center at 1-800-464-4000 or 1-800-390-3510 (TTY users call 1-800-777-1370)
- For all other issues, you can submit your grievance in one of the following ways:
  - to the Member Services Department at a Plan Facility (please refer to *Your Guidebook* for addresses)
  - by calling our Member Service Call Center at 1-800-464-4000 (TTY users call 1-800-777-1370)
  - through our website at **kp.org**

We will send you a confirmation letter within five days after we receive your grievance. We will send you our written decision within 30 days after we receive your grievance. If we do not approve your request, we will tell you the reasons and about additional dispute resolution options. Note: If we resolve your issue to your satisfaction by the end of the next business day after we receive your grievance orally, by fax, or through our website, and a Member Services representative notifies you orally about our decision, we will not send you a confirmation letter or a written decision unless your grievance involves a coverage dispute, a dispute about whether a Service is Medically Necessary, or an experimental or investigational treatment.

Expedited grievance

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

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

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

- Call our Expedited Review Unit toll free at 1-888-987-7247 (TTY users call 1-800-777-1370), which is available Monday through Saturday from 8:30 a.m. to 5 p.m. After hours, you may leave a message and a representative will return your call the next business day
- Send your written request to:
  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 23170
  Oakland, CA 94623-0170
- Fax your written request to our Expedited Review Unit toll free at 1-888-987-2252
- Deliver your request in person to your local Member Services Department at a Plan Facility

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

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

Supporting Documents

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

Who May File

The following persons may file a grievance:

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

Department of Managed Health Care Complaints

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

Independent Medical Review (IMR)

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

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

- One of these situations applies to you:
  - you have a recommendation from a provider requesting Medically Necessary Services
  - you have received Emergency Services, emergency ambulance Services, or Urgent Care from a provider who determined the Services to be Medically Necessary
  - you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition
- Your request for payment or Services has been denied, modified, or delayed based in whole or in part on a decision that the Services are not Medically Necessary
- You have filed a grievance and we have denied it or we haven't made a decision about your grievance

within 30 days (or three days for expedited grievances). The Department of Managed Health Care may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function

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

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

Experimental or investigational denials

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

- Your treating physician provided us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we cover than the therapy being requested. "Life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity
- If your treating physician is a Plan Physician, he or she recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying his or her recommendation
- You (or your Non–Plan Physician who is a licensed, and either a board-certified or board-eligible, physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician's certification included a statement of the evidence relied upon by the physician in certifying his or her recommendation. We do not cover the Services of the Non–Plan Provider

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

Binding Arbitration

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

Scope of arbitration

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

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *Membership Agreement and Evidence of Coverage* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. (Health Plan), including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, Services, irrespective of the legal theories upon which the claim is asserted
- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- The claim is *not* within the jurisdiction of the Small Claims Court

- If coverage under this *Membership Agreement and Evidence of Coverage* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), the claim is *not* about an "adverse benefit determination" as defined in that regulation. Note: Claims about "adverse benefit determinations" are excluded from this binding arbitration requirement only until such time as the regulation prohibiting mandatory binding arbitration of this category of claim (29 CFR 2560.503-1(c)(4)) is modified, amended, repealed, superseded, or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without further notice

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

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

"Kaiser Permanente Parties" include:

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

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

Initiating arbitration

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

Serving Demand for Arbitration

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

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

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

Filing fee

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

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

Number of arbitrators

The number of arbitrators may affect the Claimant's responsibility for paying the neutral arbitrator's fees and expenses.

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing that the arbitration shall be heard by two party arbitrators and one neutral arbitrator.

The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

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

Payment of arbitrators' fees and expenses

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

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs

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

Rules of Procedure

Arbitrations shall be conducted according to the Rules of Procedure developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from our Member Service Call Center.

General provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondents served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

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

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

Termination of Membership

Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2011, your last minute of coverage was at 11:59 p.m. on December 31, 2010). You will be billed as a non-Member for any Services you receive after your membership terminates. When your membership terminates, Health Plan and Plan Providers have no further liability or responsibility under this *Membership Agreement and Evidence of Coverage*, except as provided under "Payments after Termination" in this "Termination of Membership" section.

How You May Terminate Your Membership

You may terminate your membership by sending written notice, signed by the Subscriber, to the address below. Your membership will terminate at 11:59 p.m. on the last day of the month in which we receive your notice. Also, you must include with your notice all amounts payable related to this *Membership Agreement and Evidence of Coverage*, including Premiums, for the period prior to your termination date.

Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 23059
San Diego, CA 92193-3059

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership will end at 11:59 p.m. on the last day of that month. For example, if you become ineligible on December 5, 2010, your termination date is January 1, 2011, and your last minute of coverage is at 11:59 p.m. on December 31, 2010.

Termination for Cause

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

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

After your first 24 months of individuals and families coverage, we may not terminate you for cause solely because you gave us incorrect or incomplete material information in your Health Coverage Application.

If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future. We may also report criminal fraud and other illegal acts to the authorities for prosecution.

Termination for Nonpayment of Premiums

If we terminate this *Membership Agreement and Evidence of Coverage* because we did not receive the required Premiums when due, then the membership of the Subscriber will end retroactively at 11:59 p.m. on the last day of the most recent month for which we received a full Premium payment. This retroactive period will not exceed 60 days before the date we mail the Subscriber a notice confirming termination of membership (a "Termination Notice").

If we do not receive full Premium payment on or before the 20th day of the coverage month, we will send a notice of nonreceipt of payment (a "Late Notice") to the Subscriber's address of record. This Late Notice will include the following information:

- A statement that we have not received full Premium payment and that we will terminate this *Membership Agreement and Evidence of Coverage* for nonpayment if we do not receive the required Premiums within 30 days after the date we mailed the Late Notice
- The specific date and time when the membership of the Subscriber will end if we do not receive the required Premiums

We will mail a Termination Notice to the Subscriber's address of record if we do not receive full Premium payment within 30 days after the date we mailed the Late Notice. The Termination Notice will include the following information:

- A statement that we have terminated this *Membership Agreement and Evidence of Coverage* for nonpayment of Premiums
- The specific date and time when the membership of the Subscriber ended
- Information explaining whether or not the Subscriber can reinstate this *Membership Agreement and Evidence of Coverage*

Reinstatement after termination for nonpayment of Premiums

Persons terminated for nonpayment of Premiums may not enroll in Health Plan even after paying all amounts owed unless we approve the enrollment.

If we terminate this *Membership Agreement and Evidence of Coverage* for nonpayment of Premiums, we will permit reinstatement of this *Membership Agreement and Evidence of Coverage* three times during any 12-month period if we receive the amounts owed within 15

days of the date of the Late Notice. We will not reinstate this *Membership Agreement and Evidence of Coverage* if you do not obtain reinstatement of your terminated *Membership Agreement and Evidence of Coverage* within the required 15 days, or if we terminate the *Membership Agreement and Evidence of Coverage* for nonpayment of Premiums more than three times in a 12-month period.

Termination for Discontinuance of a Product

We may terminate your membership if we discontinue offering this product as permitted or required by law. If we continue to offer other individual (nongroup) products, we may terminate your membership under this product by sending you written notice at least 90 days before the termination date. You will be able to enroll in any other product we are then offering in the individual (nongroup) market if you meet all eligibility requirements (except for any medical review requirement). If we discontinue offering all individual (nongroup) products, we may terminate your membership by sending you written notice at least 180 days before the termination date.

Payments after Termination

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

- Within 30 days, refund any amounts we owe for Premiums you paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Emergency Services and Urgent Care" and "Dispute Resolution" sections

We will deduct any amounts you owe Health Plan or Plan Providers from any payment we make to you.

State Review of Membership Termination

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

Miscellaneous Provisions

Administration of this *Membership Agreement and Evidence of Coverage*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this *Membership Agreement and Evidence of Coverage*.

Advance directives

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

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

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

Membership Agreement and Evidence of Coverage binding on Members

By electing coverage or accepting benefits under this *Membership Agreement and Evidence of Coverage*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *Membership Agreement and Evidence of Coverage*.

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 *Membership Agreement and Evidence of Coverage*.

Assignment

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

Attorney and advocate fees and expenses

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

Claims review authority

We are responsible for determining whether you are entitled to benefits under this *Membership Agreement and Evidence of Coverage* and we have the discretionary authority to review and evaluate claims that arise under this *Membership Agreement and Evidence of Coverage*. We conduct this evaluation independently by interpreting the provisions of this *Membership Agreement and Evidence of Coverage*. If coverage under this *Membership Agreement and Evidence of Coverage* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), then we are a "named claims fiduciary" to review claims under this *Membership Agreement and Evidence of Coverage*.

Governing law

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

Health Insurance Counseling and Advocacy Program (HICAP)

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

No waiver

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

Nondiscrimination

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

Notices

Our notices to you will be sent to the most recent address we have for the Subscriber, except that if the Subscriber has chosen to receive these membership agreement and evidence of coverage documents online we will notify the Subscriber at the most recent email address we have for the Subscriber when notices related to amendment of this *Membership Agreement and Evidence of Coverage* are posted on our website at **kp.org**. The Subscriber is responsible for notifying us of any change in address. Subscribers who move (or change their e-mail address if the Subscriber has chosen to receive these membership agreement and evidence of coverage documents on our website) should call our Member Service Call Center as soon as possible to give us their new address. If a Member does not reside with the Subscriber, he or she should contact our Member Service Call Center to discuss alternate delivery options.

Other formats for Members with disabilities

You can request a copy of this *Membership Agreement and Evidence of Coverage* in an alternate format (Braille, audio, electronic text file, or large print) by calling our Member Service Call Center.

Overpayment recovery

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

Privacy practices

Kaiser Permanente will protect the privacy of your protected health information. We also require contracting providers to protect your protected health information. Your protected health information is individually-identifiable information (oral, written, or electronic) about your health, health care services you receive, or payment for your health care. You may generally see and receive copies of your protected health information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your protected health information.

We may use or disclose your protected health information for treatment, health research, payment, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give protected health information to others, such as government agencies or in judicial actions. We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices*, which provides additional information about our privacy practices and your rights regarding your protected health information is available and will be furnished to you upon request. To request a copy, please call our Member Service Call Center. You can also find the notice at your local Plan Facility or on our website at kp.org.

Public policy participation

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

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

Telephone access (TTY)

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

Helpful Information

Your Guidebook to Kaiser Permanente Services (Your Guidebook)

Please refer to *Your Guidebook* for helpful information about your coverage, such as:

- The types of covered Services that are available from each Plan Facility in your area
- How to use our Services and make appointments
- Hours of operation
- Appointments and advice phone numbers

You can get a copy of *Your Guidebook* by visiting our website at **kp.org** or by calling our Member Service Call Center.

How to Reach Us

Appointments

If you need to make an appointment, please call us or visit our website:

Call	The appointment phone number at a Plan Facility (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for phone numbers)
Website	**kp.org** for routine (non-urgent) appointments with your personal Plan Physician or another Primary Care Physician

Not sure what kind of care you need?

If you need advice on whether to get medical care, or how and when to get care, we have licensed health care professionals available to assist you by phone 24 hours a day, 7 days a week:

Call	The appointment or advice phone number at a Plan Facility (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for phone numbers)

Member Services

If you have questions or concerns about your coverage, how to obtain Services, or the facilities where you can receive care, you can reach us by calling, writing, or visiting our website:

Call	**1-800-464-4000** **1-800-390-3510 (TTY)** Weekdays 7 a.m. to 7 p.m., and weekends 7 a.m. to 3 p.m. (except holidays)
Write	Member Services Department at a Plan Facility (refer to *Your Guidebook* for addresses)
Website	**kp.org**

Authorization for Post-Stabilization Care

If you need to request authorization for Post-Stabilization Care as described under "Emergency Services" in the "Emergency Services and Urgent Care" section, please call us:

Call	**1-800-225-8883** or the notification telephone number on your Kaiser Permanente ID card **711 (TTY)** Call any time

Help with claim forms for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

If you need a claim form to request payment or reimbursement for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits and Cost Sharing" section, or if you need help completing the form, you can reach us by calling or by visiting our website.

Call	**1-800-464-4000** or **1-800-390-3510** **1-800-777-1370 (TTY)** Weekdays 7 a.m. to 7 p.m., and weekends 7 a.m. to 3 p.m. (except holidays)
Website	**kp.org**

Submitting claims for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

If you need to submit a completed claim form for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits and Cost Sharing" section, or if you need to submit other information that we request about your claim, send it to our Claims Department:

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

Payment Responsibility

This "Payment Responsibility" section briefly explains who is responsible for payments related to the health care coverage described in this *Membership Agreement and Evidence of Coverage.* Payment responsibility is more fully described in other sections of the *Membership Agreement and Evidence of Coverage* as described below:

- The Subscriber is responsible for paying Premiums (refer to "Premiums" in the "Premiums, Eligibility, and Enrollment" section)
- You are responsible for paying Cost Sharing for covered Services (refer to "Cost Sharing" in the "Benefits and Cost Sharing" section)
- If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider, or if you receive emergency ambulance Services, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us (refer to "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)
- If you receive Services from Non–Plan Providers that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services) and you want us to pay for the care, you must submit a grievance (refer to "Grievances" in the "Dispute Resolution" section)
- If you have Medicare, we will coordinate benefits with the other coverage (refer to "Coordination of Benefits" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- In some situations, you or a third party may be responsible for reimbursing us for covered Services (refer to "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- You are responsible for paying the full price for noncovered Services

Chiropractic Services Amendment

This "Chiropractic Services Amendment" amends your *Individual Plan Membership Agreement and Disclosure Form and Evidence of Coverage* for Kaiser Permanente HIPAA Individual Plan to include coverage for Medically Necessary Chiropractic Services under the following terms and conditions.

All provisions of the *Membership Agreement and Evidence of Coverage* apply to coverage described in this document except for the following sections:

- "How to Obtain Services" (except that the "Completion of Services from Non–Plan Providers" or for Kaiser Permanente Senior Advantage or Medicare Cost Members, the "Termination of a Plan Provider's contract and completion of Services" section does apply to coverage described in this document)
- "Plan Facilities"
- "Emergency Services and Urgent Care"
- "Benefits and Cost Sharing" (except that the "Annual out-of-pocket maximum" section does apply to coverage described in this document)

Kaiser Foundation Health Plan, Inc. contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to make the ASH Plans network of Participating Chiropractors available to you. When you need chiropractic care, you have direct access to more than 2,800 licensed chiropractors in California. You can

obtain covered Services from any Participating Chiropractor without a referral from a Plan Physician. Cost Sharing is due when you receive covered Services.

Definitions

In addition to the terms defined in the "Definitions" section of your Health Plan *Membership Agreement and Evidence of Coverage*, the following terms, when capitalized and used in any part of this "Chiropractic Services Amendment" have the following meaning:

Chiropractic Services: Chiropractic Services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic appliances) for the treatment of your Neuromusculoskeletal Disorder.

Emergency Chiropractic Services: Covered Chiropractic Services provided for the treatment of a sudden and unexpected onset of a Neuromusculoskeletal Disorder which manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate Chiropractic Services to result in serious jeopardy to your health or body functions or organs.

Neuromusculoskeletal Disorders: Conditions with associated signs and symptoms related to the nervous, muscular, or skeletal systems. Neuromusculoskeletal Disorders are conditions typically categorized as structural, degenerative, or inflammatory disorders, or biomechanical dysfunction of the joints of the body or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs, and synovial structures), and related neurological manifestations or conditions.

Non–Participating Chiropractor: A chiropractor other than a Participating Chiropractor.

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

Participating Chiropractor: A chiropractor who is licensed to provide chiropractic services in California and who has a contract with ASH Plans to provide Medically Necessary Chiropractic Services to you. A list of Participating Chiropractors is available on the ASH Plans website at **ashplans.com** or from the ASH Plans Member Services Department toll free at **1-800-678-9133** (TTY users call **711**). The list of Participating Chiropractors is subject to change at any time, without notice. If you have questions, please call the ASH Plans Member Services Department.

Participating Provider: A Participating Chiropractor or any licensed provider with which ASH Plans contracts to provide covered care, including laboratory tests or X-rays that are covered chiropractic care.

Treatment Plan: A proposed course of treatment for your Neuromusculoskeletal Disorder, which may include laboratory tests, X-rays, chiropractic appliances, and a specific number of visits for chiropractic manipulations, adjustments, and therapies that are Medically Necessary Chiropractic Services for you.

Participating Providers

Please read the following information so you will know from whom or what group of providers you may receive covered chiropractic services.

ASH Plans contracts with Participating Chiropractors and other Participating Providers to provide covered Chiropractic Services (including laboratory tests, X-rays, and chiropractic appliances). You must receive Services covered under this "Chiropractic Services Amendment" from a Participating Provider, except for Emergency Chiropractic Services and Services that are not available from Participating Providers that are authorized in advance by ASH Plans.

How to obtain Services

To obtain Services covered under this "Chiropractic Services Amendment," call a Participating Chiropractor to schedule an initial examination. If additional Services are required, your Participating Chiropractor will prepare a Treatment Plan. The ASH Plans Clinical Services Manager will authorize the Treatment Plan if the Services are Medically Necessary Chiropractic Services for you. ASH Plans will disclose to you, upon request, the process that it uses to authorize a Treatment Plan. If you have questions or concerns, please contact ASH Plans or Kaiser Permanente as described under "Member Services" in this "Chiropractic Services Amendment."

Covered Services

We cover the Services listed in this "Covered Services" section, subject to exclusions described under "Exclusions" in the "Exclusions and Limitations" section, only if all of the following conditions are satisfied:

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary

- ASH Plans has authorized the Services as part of your Treatment plan, except for:
  - the initial examination described under "Office Visits" in this "Covered Services" section
  - Emergency Chiropractic Services described under "Emergency Chiropractic Services" in this "Covered Services" section
- You receive the Services from Participating Providers, except for:
  - Emergency Chiropractic Services described under "Emergency Chiropractic Services" in this "Covered Services" section
  - Services that are not available from Participating Providers that are authorized in advance by ASH Plans

Covered Services are provided at the Cost Sharing listed in this "Covered Services" section. However, you may be liable for the cost of noncovered services you obtain from Participating Providers or Non–Participating Providers.

The Cost Sharing you pay for Services covered under this "Chiropractic Services Amendment" does not apply toward the annual out-of-pocket maximum described in your Health Plan *Membership Agreement and Evidence of Coverage*.

Coverage of chiropractic Services under this "Chiropractic Services Amendment" is different from the coverage of chiropractic Services under "Outpatient Care" in the "Benefits and Cost Sharing" section of the *Membership Agreement and Evidence of Coverage*. You do not need a referral to get covered Services under this "Chiropractic Services Amendment," but covered Services and Cost Sharing may differ from those under "Outpatient Care" in the "Benefits and Cost Sharing" section of the *Membership Agreement and Evidence of Coverage*. If you receive chiropractic Services for which you have a referral, as described under "Getting a Referral" in the "How to Obtain Services" section of the *Membership Agreement and Evidence of Coverage*, then unless you tell us otherwise, we will assume that you are using your coverage under "Outpatient Care" in the "Benefits and Cost Sharing" section of the *Membership Agreement and Evidence of Coverage*.

Office visits

We cover up to a combined total of 20 of the following types of office visits per calendar year at **a $15 Copayment per visit**:

- **Chiropractic office visits.** Each office visit counts toward the calendar year visit limit even if an adjustment is not provided during the visit:
  - **Initial examination:** An examination performed by a Participating Chiropractor to determine the nature of your problem (and, if appropriate, to prepare a Treatment Plan), and to provide Medically Necessary Chiropractic Services, which may include an adjustment and adjunctive therapy (such as ultrasound, hot packs, cold packs, or electrical muscle stimulation). We cover an initial examination only if you have not already received covered Services from a Participating Chiropractor in the same calendar year for your Neuromusculoskeletal Disorder
  - **Subsequent office visits:** Subsequent Participating Chiropractor office visits for Medically Necessary Chiropractic Services, which may include an adjustment, adjunctive therapy, and a re-examination to assess the need to continue, extend, or change a Treatment Plan

Laboratory tests and X-rays

We cover Medically Necessary laboratory tests and X-rays when prescribed as part of covered chiropractic care described under "Office visits" in this "Covered Services" section at **no charge** when a Participating Chiropractor provides the Services or refers you to a Participating Provider for the Services.

Chiropractic appliances

We provide a **$50 Allowance per calendar year** toward the ASH Plans fee schedule price for chiropractic appliances listed in this paragraph when the item is prescribed and provided to you by a Participating Chiropractor as part of covered chiropractic care described under "Office visits" in this "Covered Services" section. If the price of the item(s) in the ASH Plans fee schedule exceeds $50 (the Allowance), you will pay the amount in excess of $50 (and that payment does not apply toward your annual out-of-pocket maximum). Covered chiropractic appliances are limited to: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle braces, knee braces, rib supports, and wrist braces.

Second opinions

If you request a second opinion, it will be provided to you by a Participating Chiropractor who is an appropriately qualified chiropractor (a chiropractor who is acting within his or her scope of practice and who possesses a clinical background related to the illness or condition associated with the request for a second opinion). To get a second opinion, make an appointment with a Participating Chiropractor. Second opinion office visits are provided at **a $15 Copayment per visit** and count toward your annual visit limit unless a Participating Chiropractor refers you to another Participating Chiropractor for a consultation that does not include treatment. If ASH Plans determines that there isn't a Participating Chiropractor who is an appropriately qualified chiropractor for your condition, ASH Plans will authorize a referral to a Non–Participating Chiropractor for a second opinion.

Emergency Chiropractic Services

Emergency Chiropractic Services. We cover Emergency Chiropractic Services provided by a Participating Chiropractor or a Non–Participating Chiropractor at **a $15 Copayment per visit.** We do not cover follow-up or continuing care from a Non–Participating Chiropractor unless ASH Plans has authorized the Services in advance. Also, we do not cover Services from a Non-Participating Chiropractor that ASH Plans determines are not Emergency Chiropractic Services.

How to file a claim. As soon as possible after receiving Emergency Chiropractic Services, you must file an ASH Plans claim form. To request a claim form or for more information, please call ASH Plans toll free at **1-800-678-9133** (TTY users call **711**). You must send the completed claim form to:

ASH Plans
P.O. Box 509002
San Diego, CA 92150-9002

Exclusions and Limitations

Exclusions

The Services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this "Chiropractic Services Amendment":

- Any Services not provided by a Participating Chiropractor or Participating Provider, except for Emergency Chiropractic Services, and Services that are not available from Participating Providers but that are authorized in advance by ASH Plans
- Services for asthma or addiction, such as nicotine addiction
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Thermography
- Experimental or investigational Services. Please refer to the "Dispute Resolution" section in your Health Plan *Membership Agreement and Evidence of Coverage* for information about Independent Medical Review related to denied requests for Medically Necessary and experimental or investigational Services
- MRI, CT, PET, bone scans, nuclear radiology, and any types of diagnostic radiology other than X-rays covered under the "Covered Services" section of this "Chiropractic Services Amendment"
- Ambulance and other transportation
- Education programs, non-medical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
- Services for pre-employment physicals or vocational rehabilitation
- Air conditioners, air purifiers, therapeutic mattresses, chiropractic appliances, durable medical equipment, supplies, devices, appliances, and any other item except those listed as covered under "Chiropractic appliances" in the "Covered Services" section of this "Chiropractic Services Amendment"
- Drugs and medicines, including non-legend or proprietary drugs and medicines
- Services you receive outside the state of California, except for Emergency Chiropractic Services
- Hospital services, anesthesia, manipulation under anesthesia, and related services
- For chiropractic services, adjunctive therapy not associated with spinal, muscle, or joint manipulations
- Dietary and nutritional supplements, including vitamins, minerals, herbs, herbal products, injectable supplements, and similar products
- Massage therapy
- Services provided by a chiropractor that are not within the scope of licensure for a chiropractor licensed in California
- Maintenance care (services provided to Members whose treatment records indicate he or she has reached maximum therapeutic benefit)

Member Services

If you have a question or concern regarding the Services you received from a Participating Provider, you may call ASH Plans Member Services toll free at **1-800-678-9133** (TTY users call **711**) weekdays from 5 a.m. to 6 p.m., or write ASH Plans at:

ASH Plans
Member Services
P.O. Box 509002
San Diego, CA 92150-9002

Grievances

You can file a grievance with Kaiser Permanente regarding any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about Services you received. You may submit your grievance orally or in writing to Kaiser Permanente as described in the "Dispute Resolution" section of your Health Plan *Membership Agreement and Evidence of Coverage*.

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