

Kaiser Permanente Basic Plan

Health Maintenance Organization (HMO)



Evidence of Coverage for the Basic Plan

Effective January 1, 2017

Contracted by the CalPERS Board of Administration Under the
Public Employees' Medical & Hospital Care Act (PEMHCA)

This *Evidence of Coverage*, the *Group Agreement (Agreement)*, and any amendments constitute the contract between Kaiser Foundation Health Plan, Inc., and CalPERS. The *Agreement* is on file and available for review in the office of the CalPERS Health Plan Administration Division, 400 Q St, Sacramento, CA 95811. The *Agreement* contains additional terms such as Premiums, when coverage can change, the effective date of coverage, and the effective date of termination. The *Agreement* must be consulted to determine the exact terms of coverage. It is in your best interest to familiarize yourself with this *Evidence of Coverage*.

THERE IS NO VESTED RIGHT TO RECEIVE ANY PARTICULAR BENEFIT SET FORTH IN THE PLAN. PLAN BENEFITS MAY BE MODIFIED. ANY MODIFIED BENEFIT (SUCH AS THE ELIMINATION OF A PARTICULAR BENEFIT OR AN INCREASE IN THE MEMBER'S COPAYMENT) APPLIES TO SERVICES OR SUPPLIES FURNISHED ON OR AFTER THE EFFECTIVE DATE OF THE MODIFICATION

Health Care Reform

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation Act of 2010, expands health coverage for various groups and provides mechanisms to lower costs and increase benefits for Americans with health insurance. As federal regulations are released for various measures of the law, CalPERS may need to modify benefits accordingly. For up-to-date information about CalPERS and Health Care Reform, please refer to the Health Care Reform page on CalPERS On-Line at www.calpers.ca.gov.

Help in your language

Interpreter services, including sign language, are available during all hours of operation 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 request health plan materials translated in your language, and may also request these materials in large text or in other formats to accommodate your needs. For more information, call our Member Service Contact Center 24 hours a day, seven days a week (except closed holidays) at **1-800-464-4000** (TTY users call **711**).

Ayuda en su idioma

Se ofrecen servicios de intérprete sin costo alguno para usted durante todo el horario de atención, incluida la lengua de señas (sign language). También podemos ofrecerles a usted y a sus familiares y amigos todo tipo de ayuda especial que necesiten para tener acceso a nuestros centros y servicios. Además, puede solicitar que los materiales del plan de salud se traduzcan a su idioma y que estos materiales sean con letra grande o en otros formatos que se acomoden a sus necesidades. Para obtener más información, llame a la Central de Llamadas de Servicio a los Miembros las 24 horas del día, los siete días de la semana (excepto los días festivos y después de las 5 p.m. el día después de Thanksgiving [Día de Acción de Gracias], y las vísperas de Navidad y Año Nuevo) al **1-800-788-0616** (usuarios de TTY llamen al **711**).

以您的語言提供協助

我們在辦公時間內免費為您提供口譯服務，包括手語在內。我們也可以向您本人、您的家人和朋友提供使用我們設施和服務時所需的任何特別協助。此外，您可以要求將會員資料翻譯成您的語言，並且要求這些資料以大字版或其他格式來滿足您的需求。如需更多資訊，請致電我們的會員服務電話中心，我們每週7天，每天24小時為您服務（節假日全天以及感恩節翌日、聖誕節前夕和新年前夕下午5時後休息），電話號碼是 **1-800-757-7585**（免費電話）（TTY使用者請撥**711**）。

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

A nonprofit corporation

Kaiser Permanente Basic Plan Evidence of Coverage

January 1, 2017, through December 31, 2017

Member Service Contact Center
24 hours a day, seven days a week
(except closed holidays)
1-800-464-4000 toll free
711 (toll free TTY for the hearing/speech impaired)
kp.org

Benefit Changes for Current Year

The following is a summary of the most important coverage changes and clarifications that we have made to this Basic Plan 2017 *Evidence of Coverage*. Please read this *Evidence of Coverage* for the complete text of these changes, as well as changes not listed in the summary below. In addition, please refer to the "Premiums" section for information about 2017 Premiums.

Please refer to the "Benefits, Copayments, and Coinsurance" section in this *Evidence of Coverage* for benefit descriptions and the amount Members must pay for covered benefits. Benefits are also subject to the "Emergency Services and Urgent Care" and the "Exclusions, Limitations, Coordination of Benefits, and Reductions" sections in this *Evidence of Coverage*.

Acupuncture Services

We have revised the definition of Acupuncture Services under the "Combined Chiropractic and Acupuncture Services Amendment" to remove cupping as a form of adjunctive therapy.

Drug out of pocket maximum

The drug Maximum Out of Pocket (MOOP) has been revised as follows to incorporate the 2017 Federal MOOP increase:

- *\$5,650 per calendar year for self-only enrollment (a Family of one Member)*
- *\$5,650 per calendar year for any one Member in a Family of two or more Members*
- *\$11,300 per calendar year for an entire Family of two or more Members*

Visiting Member Services Copayment or Coinsurance

"Visiting Member Services" are Services that are covered under your Home Region plan and that you receive in another Region. The Copayment or Coinsurance for Visiting Member Services are the same as the Copayment or Coinsurance for covered Services in the Member's Home Region.

Second Opinions

Under "Second Opinions" in the "How to Obtain Services" section, we have clarified how a Member may obtain a second opinion.

Outpatient prescription drugs

Sexual dysfunction drugs are now subject to a per prescription maximum.

Also, we have added text to both the standard procedure and urgent procedure descriptions of the grievance process in the "Dispute Resolution" section of your EOC to include timeframes for grievances concerning denials for non-formulary drug coverage requests. Non-formulary drugs are drugs not listed on our drug formulary for your condition.

Basic Plan Benefit Summary

Accumulation Period

The Accumulation Period for this plan is 1/1/17 through 12/31/17 (calendar year).

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum or the Drug Out-of-Pocket Maximum, you will not pay any more Copayments or Coinsurance for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	\$1,500	\$1,500	\$3,000
Drug Out-of-Pocket Maximum	\$5,650	\$5,650	\$11,300
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)

You Pay

Most Primary Care Visits and most Non-Physician Specialist Visits	\$15 per visit
Most Physician Specialist Visits	\$15 per visit
Routine physical maintenance exams, including well-woman exams.....	No charge
Well-child preventive exams (through age 23 months).....	No charge
Family planning counseling and consultations.....	No charge
Scheduled prenatal care exams.....	No charge
Routine eye exams with a Plan Optometrist.....	No charge
Hearing exams.....	No charge
Urgent care consultations, evaluations, and treatment	\$15 per visit
Most physical, occupational, and speech therapy.....	\$15 per visit

Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures	\$15 per procedure
Allergy injections (including allergy serum).....	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests.....	No charge
Covered individual health education counseling	No charge
Covered health education programs	No charge

Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs .	No charge
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Emergency Health Coverage

You Pay

Emergency Department visits	\$50 per visit
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Note: This Copayment does not apply if you are held for observation in a hospital unit outside the Emergency Department or if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Copayment or Coinsurance).

Ambulance Services

You Pay

Ambulance Services.....	No charge
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Prescription Drug Coverage

You Pay

Covered outpatient items in accord with our drug formulary guidelines:

Most generic items at a Plan Pharmacy.....	\$5 for up to a 30-day supply
Most generic refills through our mail-order service	\$10 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy	\$20 for up to a 30-day supply
Most brand-name refills through our mail-order service.....	\$40 for up to a 100-day supply

Durable Medical Equipment (DME)

You Pay

DME items in accord with our DME formulary guidelines	No charge
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Mental Health Services	You Pay
Inpatient psychiatric hospitalization.....	No charge
Individual outpatient mental health evaluation and treatment.....	\$15 per visit
Group outpatient mental health treatment	\$7 per visit
Chemical Dependency Services	You Pay
Inpatient detoxification.....	No charge
Individual outpatient chemical dependency evaluation and treatment	\$15 per visit
Group outpatient chemical dependency treatment	\$5 per visit
Home Health Services	You Pay
Home health care.....	No charge
Other	You Pay
Hearing aid(s) every 36 months	Amount in excess of \$1,000 Allowance
Skilled Nursing Facility care (up to 100 days per benefit period).....	No charge
Prosthetic and orthotic devices	No charge
All Services related to covered infertility treatment.....	50% Coinsurance
Hospice care	No charge

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

Introduction

This *Evidence of Coverage* describes our "Basic Plan" health care coverage provided under the *Group Agreement (Agreement)* between Health Plan (Kaiser Foundation Health Plan, Inc., Northern California Region and Southern California Region) and your Group (CalPERS).

For benefits provided under any other Health Plan program, refer to that plan's evidence of coverage. For benefits provided under any other program offered by your Group (for example, workers compensation benefits), refer to your Group's materials.

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

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), which we call your "Home Region." The Service Area of each Region is described in the "Definitions" section of this *Evidence of Coverage*. The coverage information in this *Evidence of Coverage* applies when you obtain care in your Home Region. When you visit the other California Region, you may receive care as described in "Visiting Other Regions" in the "How to Obtain Services" section.

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY GET HEALTH CARE.

It is important to familiarize yourself with your coverage by reading this *Evidence of Coverage* completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

Term of this Evidence of Coverage

This *Evidence of Coverage* is for the period January 1, 2017, through December 31, 2017, unless amended. Your Health Benefits Officer (or, if you are retired, the CalPERS Member Account Management Division) can tell you whether this *Evidence of Coverage* is still in effect and give you a current one if this *Evidence of Coverage* has expired or been amended.

About Kaiser Permanente

Kaiser Permanente provides Services directly to our Members through an integrated medical care program. Health Plan, Plan Hospitals, and the Medical Group work together to provide our Members with quality care. Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital care, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *Evidence of Coverage*. 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 your Home Region Service Area, which is described in the "Definitions" section. You must receive all covered care from Plan Providers inside your Home Region 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
- Chiropractic and acupuncture services as described in the "ASH Plans Combined Chiropractic and Acupuncture Services" section
- Durable medical equipment as described under "Durable Medical Equipment for Home Use" in the "Benefits, Copayments, and Coinsurance" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits, Copayments, and Coinsurance" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Home health care as described under "Home Health Care" in the "Benefits, Copayments, and Coinsurance" section
- Hospice care as described under "Hospice Care" in the "Benefits, Copayments, and Coinsurance" section
- Visiting Member Services as described under "Receiving Care in the Service Area of another Region" in the "How to Obtain Services" section
- Ostomy and urological supplies as described under "Ostomy and Urological Supplies" in the "Benefits, Copayments, and Coinsurance" section
- Prosthetics and orthotics as described under "Prosthetic and Orthotic Devices" in the "Benefits, Copayments, and Coinsurance" section

Definitions

Some terms have special meaning in this *Evidence of Coverage*. When we use a term with special meaning in only one section of this *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 *Evidence of Coverage*.

Adult Member: A Member who is age 19 or older and is not a Pediatric Member. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1.

Allowance: A specified credit amount that you can use toward the purchase price of an item. If the price of the item(s) you select exceeds the Allowance, you will pay the amount in excess of the Allowance (and that payment will not apply toward any deductible or out-of-pocket maximum).

Calendar Year: January 1 to December 31.

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 a Copayment or Coinsurance from its payment, the amount Kaiser Permanente would have paid if it did not subtract a Copayment or Coinsurance)

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service under this *Evidence of Coverage*.

Copayment: A specific dollar amount that you must pay when you receive a covered Service under this *Evidence*

of Coverage Note: The dollar amount of the Copayment can be \$0 (no charge).

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

Dependent: A Member who meets the eligibility requirements as a Dependent, a subscriber's spouse or domestic partner, as defined in California Government Code section 22770, or a child, as defined in Title 2, California Code of Regulations, Section 599.500 (for Dependent eligibility requirements, see "Eligibility" in the "Premiums, Eligibility, and Enrollment" section).

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable person would have believed that the absence of immediate medical attention would 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)

Employer: Any person, firm, proprietary or non-profit corporation, partnership, public agency or association that has at least two employees and that is actively

engaged in business or service, in which a bona fide employer-employee relationship exists, in which the majority of employees were employed within this state, and which was not formed primarily for purposes of buying health care coverage or insurance.

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

Experimental: 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

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

Group: California Public Employees Retirement System (CalPERS).

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

Home Region: The Region where you enrolled (either the Northern California Region or the Southern California Region).

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

Infertility: Means not being able get pregnant or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception or having a medical or other demonstrated condition that is recognized by a Plan Physician as a cause of infertility.

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

Medical Group: For Northern California Region Members, The Permanente Medical Group, Inc., a for-profit professional corporation, and for Southern California Region Members, the Southern California

Permanente Medical Group, a for-profit professional partnership.

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

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

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

Non-Physician Specialist Visits: Consultations, evaluations, and treatment by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

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.

Open Enrollment Period: A fixed time period designated by CalPERS to initiate enrollment or change enrollment from one plan to another.

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 your Home Region Service Area
- A reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to your Home Region Service Area

Pediatric Member: A Member from birth through the end of the month of his or her 19th birthday. For example, if you turn 19 on June 25, you will be an Adult

Member starting July 1 and your last minute as a Pediatric Member will be 11:59 p.m. on June 30.

Physician Specialist Visits: Consultations, evaluations, and treatment by physician specialists, including personal Plan Physicians who are not Primary Care Physicians.

Plan Deductible: The amount you must pay in the 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, Copayments, and Coinsurance" section to learn whether your coverage includes a Plan Deductible, the Services that are subject to the Plan Deductible, and the Plan Deductible amount.

Plan Facility: Any facility listed on our website at kp.org/facilities for your Home Region 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 Contact Center.

Plan Hospital: Any hospital listed on our website at kp.org/facilities for your Home Region 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 Contact Center.

Plan Medical Office: Any medical office listed on our website at kp.org/facilities for your Home Region 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 Contact Center.

Plan Optical Sales Office: An optical sales office owned and operated by Kaiser Permanente or another optical sales office that we designate. Please refer to *Your Guidebook* for a list of Plan Optical Sales Offices in your area, except that Plan Optical Sales Offices are subject to change at any time without notice. For the current locations of Plan Optical Sales Offices, please call our Member Service Contact Center.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Out-of-Pocket Maximum: The total amount of Copayment or Coinsurance you must pay under this *Evidence of Coverage* in the calendar year for certain covered Services that you receive in the same calendar year. Please refer to the "Benefits, Copayments, and Coinsurance" section to find your Plan Out-of-Pocket Maximum amount and to learn which Services apply to the Plan Out-of-Pocket Maximum.

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 Contact Center.

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

Plan Provider: A Plan Hospital, 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 in a hospital (including the Emergency Department) after your treating physician determines that this condition is Stabilized.

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

Preventive Services: Covered Services that prevent or detect illness and do one or more of the following:

- Protect against disease and disability or further progression of a disease
- Detect disease in its earliest stages before noticeable symptoms develop

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*.

Primary Care Visits: Evaluations and treatment provided by Primary Care Physicians and primary care Plan Providers who are not physicians (such as nurse practitioners).

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 of each year and are currently the District of Columbia and parts of Northern California, Southern California, Colorado,

Georgia, Hawaii, Idaho, Maryland, Oregon, Virginia, and Washington. For the current list of Region locations, please visit our website at kp.org or call our Member Service Contact Center.

Service Area: Health Plan has two Regions in California. As a Member, you are enrolled in one of the two Regions (either our Northern California Region or Southern California Region), called your Home Region. This *Evidence of Coverage* describes the coverage for both California Regions.

Northern California Region Service Area

The ZIP codes below for each county are in our Northern California Service Area:

- All ZIP codes in Alameda County are inside our Northern California Service Area: 94501–02, 94505, 94514, 94536–46, 94550–52, 94555, 94557, 94560, 94566, 94568, 94577–80, 94586–88, 94601–15, 94617–21, 94622–24, 94649, 94659–62, 94666, 94701–10, 94712, 94720, 95377, 95391
- The following ZIP codes in Amador County are inside our Northern California Service Area: 95640, 95669
- All ZIP codes in Contra Costa County are inside our Northern California Service Area: 94505–07, 94509, 94511, 94513–14, 94516–31, 94547–49, 94551, 94553, 94556, 94561, 94563–65, 94569–70, 94572, 94575, 94582–83, 94595–98, 94706–08, 94801–08, 94820, 94850
- The following ZIP codes in El Dorado County are inside our Northern California Service Area: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762
- The following ZIP codes in Fresno County are inside our Northern California Service Area: 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, 93740–41, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–79, 93786, 93790–94, 93844, 93888
- The following ZIP codes in Kings County are inside our Northern California Service Area: 93230, 93232, 93242, 93631, 93656
- The following ZIP codes in Madera County are inside our Northern California Service Area: 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720
- All ZIP codes in Marin County are inside our Northern California Service Area: 94901, 94903–04, 94912–15, 94920, 94924–25, 94929–30, 94933, 94937–42, 94945–50, 94956–57, 94960, 94963–66, 94970–71, 94973–74, 94976–79
- The following ZIP codes in Mariposa County are inside our Northern California Service Area: 93601, 93623, 93653
- The following ZIP codes in Napa County are inside our Northern California Service Area: 94503, 94508, 94515, 94558–59, 94562, 94567, 94573–74, 94576, 94581, 94599, 95476
- The following ZIP codes in Placer County are inside our Northern California Service Area: 95602–04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95703, 95722, 95736, 95746–47, 95765
- All ZIP codes in Sacramento County are inside our Northern California Service Area: 94203–09, 94211, 94229–30, 94232, 94234–37, 94239–40, 94244, 94247–50, 94252, 94254, 94256–59, 94261–63, 94267–69, 94271, 94273–74, 94277–80, 94282–91, 94293–98, 94571, 95608–11, 95615, 95621, 95624, 95626, 95628, 95630, 95632, 95638–39, 95641, 95652, 95655, 95660, 95662, 95670–71, 95673, 95678, 95680, 95683, 95690, 95693, 95741–42, 95757–59, 95763, 95811–38, 95840–43, 95851–53, 95860, 95864–67, 95894, 95899
- All ZIP codes in San Francisco County are inside our Northern California Service Area: 94102–05, 94107–12, 94114–27, 94129–34, 94137, 94139–47, 94151, 94158–61, 94163–64, 94172, 94177, 94188
- All ZIP codes in San Joaquin County are inside our Northern California Service Area: 94514, 95201–15, 95219–20, 95227, 95230–31, 95234, 95236–37, 95240–42, 95253, 95258, 95267, 95269, 95296–97, 95304, 95320, 95330, 95336–37, 95361, 95366, 95376–78, 95385, 95391, 95632, 95686, 95690
- All ZIP codes in San Mateo County are inside our Northern California Service Area: 94002, 94005, 94010–11, 94014–21, 94025–28, 94030, 94037–38, 94044, 94060–66, 94070, 94074, 94080, 94083, 94128, 94143, 94303, 94401–04, 94497
- The following ZIP codes in Santa Clara County are inside our Northern California Service Area: 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
- All ZIP codes in Santa Cruz County are inside our Northern California Service Area: 95001, 95003,

95005–7, 95010, 95017–19, 95033, 95041, 95060–67, 95073, 95076–77

- All ZIP codes in Solano County are inside our Northern California Service Area: 94503, 94510, 94512, 94533–35, 94571, 94585, 94589–92, 95616, 95618, 95620, 95625, 95687–88, 95690, 95694, 95696
- The following ZIP codes in Sonoma County are inside our Northern California Service Area: 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
- All ZIP codes in Stanislaus County are inside our Northern California Service Area: 95230, 95304, 95307, 95313, 95316, 95319, 95322–23, 95326, 95328–29, 95350–58, 95360–61, 95363, 95367–68, 95380–82, 95385–87, 95397
- The following ZIP codes in Sutter County are inside our Northern California Service Area: 95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 95836–37
- The following ZIP codes in Tulare County are inside our Northern California Service Area: 93618, 93631, 93646, 93654, 93666, 93673
- The following ZIP codes in Yolo County are inside our Northern California Service Area: 95605, 95607, 95612, 95615–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99
- The following ZIP codes in Yuba County are inside our Northern California Service Area: 95692, 95903, 95961

Southern California Region Service Area

The ZIP codes below for each county are in our Southern California Service Area:

- The following ZIP codes in Kern County are inside our Southern California Service Area: 93203, 93205–06, 93215–16, 93220, 93222, 93224–26, 93238, 93240–41, 93243, 93249–52, 93263, 93268, 93276, 93280, 93285, 93287, 93301–09, 93311–14, 93380, 93383–90, 93501–02, 93504–05, 93518–19, 93531, 93536, 93560–61, 93581
- The following ZIP codes in Los Angeles County are inside our Southern California Service Area: 90001–84, 90086–91, 90093–96, 90099, 90189, 90201–02, 90209–13, 90220–24, 90230–33, 90239–42, 90245, 90247–51, 90254–55, 90260–67, 90270, 90272, 90274–75, 90277–78, 90280, 90290–96, 90301–12, 90401–11, 90501–10, 90601–10, 90623, 90630–31, 90637–40, 90650–52, 90660–62, 90670–71, 90701–

03, 90706–07, 90710–17, 90723, 90731–34, 90744–49, 90755, 90801–10, 90813–15, 90822, 90831–35, 90840, 90842, 90844, 90846–48, 90853, 90895, 90899, 91001, 91003, 91006–12, 91016–17, 91020–21, 91023–25, 91030–31, 91040–43, 91046, 91066, 91077, 91101–10, 91114–18, 91121, 91123–26, 91129, 91182, 91184–85, 91188–89, 91199, 91201–10, 91214, 91221–22, 91224–26, 91301–11, 91313, 91316, 91321–22, 91324–31, 91333–35, 91337, 91340–46, 91350–57, 91361–62, 91364–65, 91367, 91371–72, 91376, 91380–87, 91390, 91392–96, 91401–13, 91416, 91423, 91426, 91436, 91470, 91482, 91495–96, 91499, 91501–08, 91510, 91521–23, 91526, 91601–12, 91614–18, 91702, 91706, 91709, 91711, 91714–16, 91722–24, 91731–35, 91740–41, 91744–50, 91754–56, 91759, 91765–73, 91775–76, 91778, 91780, 91788–93, 91801–04, 91896, 91899, 93243, 93510, 93532, 93534–36, 93539, 93543–44, 93550–53, 93560, 93563, 93584, 93586, 93590–91, 93599

- All ZIP codes in Orange County are inside our Southern California Service Area: 90620–24, 90630–33, 90638, 90680, 90720–21, 90740, 90742–43, 92602–07, 92609–10, 92612, 92614–20, 92623–30, 92637, 92646–63, 92672–79, 92683–85, 92688, 92690–94, 92697–98, 92701–08, 92711–12, 92728, 92735, 92780–82, 92799, 92801–09, 92811–12, 92814–17, 92821–23, 92825, 92831–38, 92840–46, 92850, 92856–57, 92859, 92861–71, 92885–87, 92899
- The following ZIP codes in Riverside County are inside our Southern California Service Area: 91752, 92028, 92201–03, 92210–11, 92220, 92223, 92230, 92234–36, 92240–41, 92247–48, 92253–55, 92258, 92260–64, 92270, 92274, 92276, 92282, 92320, 92324, 92373, 92399, 92501–09, 92513–19, 92521–22, 92530–32, 92543–46, 92548, 92551–57, 92562–64, 92567, 92570–72, 92581–87, 92589–93, 92595–96, 92599, 92860, 92877–83
- The following ZIP codes in San Bernardino County are inside our Southern California Service Area: 91701, 91708–10, 91729–30, 91737, 91739, 91743, 91758–59, 91761–64, 91766, 91784–86, 91792, 92252, 92256, 92268, 92277–78, 92284–86, 92305, 92307–08, 92313–18, 92321–22, 92324–25, 92329, 92331, 92333–37, 92339–41, 92344–46, 92350, 92352, 92354, 92357–59, 92369, 92371–78, 92382, 92385–86, 92391–95, 92397, 92399, 92401–08, 92410–11, 92413, 92415, 92418, 92423, 92427, 92880
- The following ZIP codes in San Diego County are inside our Southern California Service Area: 91901–03, 91908–17, 91921, 91931–33, 91935, 91941–46, 91950–51, 91962–63, 91976–80, 91987, 92003,

92007–11, 92013–14, 92018–30, 92033, 92037–40, 92046, 92049, 92051–52, 92054–61, 92064–65, 92067–69, 92071–72, 92074–75, 92078–79, 92081–86, 92088, 92091–93, 92096, 92101–24, 92126–32, 92134–40, 92142–43, 92145, 92147, 92149–50, 92152–55, 92158–61, 92163, 92165–79, 92182, 92186–87, 92190–93, 92195–99

- The following ZIP codes in Tulare County are inside our Service Area: 93238, 93261
- The following ZIP codes in Ventura County are inside our Southern California Service Area: 90265, 91304, 91307, 91311, 91319–20, 91358–62, 91377, 93001–07, 93009–12, 93015–16, 93020–22, 93030–36, 93040–44, 93060–66, 93094, 93099, 93252

For each ZIP code listed for a county, your Home Region 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 your Home Region Service Area unless that other county is listed above and that ZIP code is also listed for that other county.

If you have a question about whether a ZIP code is in your Home Region Service Area, please call our Member Service Contact Center.

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

Services: Health care services or items ("health care" includes both physical health care and mental health care) and behavioral health treatment covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the "Benefits, Copayments, and Coinsurance" section.

Serious Emotional Disturbance: "Serious Emotional Disturbance" of a child under age 18 means a condition identified as a "mental disorder" 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.

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, or bulimia nervosa.

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.

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 person enrolled who is responsible for payment of premiums to the plan, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under this plan.

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

Premiums, Eligibility, and Enrollment

Premiums

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

State employees and annuitants

The Premiums listed below will be reduced by the amount the state of California contributes toward the cost of your health benefit plan. These contribution amounts are subject to change as a result of collective bargaining agreements or legislative action. Any such change will be accomplished by the State Controller or affected retirement system without any action on your part. For current contribution information, contact your Health Benefits Officer (or, if you are retired, the CalPERS Member Account Management Division).

State employees and annuitants	Monthly Premiums
Self only	\$662.92
Self and one Dependent	\$1,325.84
Self and two or more Dependents	\$1,723.59

Contracting agency employees and annuitants

The Premiums listed below will be reduced by the amount your contracting agency contributes toward the cost of your health benefit plan. This amount varies among contracting agencies. For assistance on calculating your net contribution, contact your Health Benefits Officer (or, if you are retired, the CalPERS Member Account Management Division). There are five geographic pricing areas. The Premiums that apply to you are based on your CalPERS address of record.

Bay Area pricing area. If you live or work in these counties: Alameda, Amador, Contra Costa, Marin, Napa, Nevada, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Sutter, Yolo, and Yuba, the monthly Premiums are:

Bay Area	Monthly Premiums
Self only	\$733.39
Self and one Dependent	\$1,466.78
Self and two or more Dependents	\$1,906.81

Sacramento pricing area. If you live or work in these counties: El Dorado, Placer or Sacramento, the monthly Premiums are:

Sacramento	Monthly Premiums
Self only	\$690.56
Self and one Dependent	\$1,381.12
Self and two or more Dependents	\$1,795.46

Other Northern California counties pricing area. If you live or work in these counties: Alpine, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Plumas, San Benito, Shasta, Sierra, Siskiyou, Stanislaus, Tehama, Trinity, and Tuolumne, the monthly Premiums are:

Other Northern California counties	Monthly Premiums
Self only	\$733.99
Self and one Dependent	\$1,467.98
Self and two or more Dependents	\$1,908.37

Los Angeles pricing area. If you live or work in Los Angeles, San Bernardino, or Ventura counties, the monthly Premiums are:

Los Angeles area	Monthly Premiums
Self only	\$573.89
Self and one Dependent	\$1,147.78
Self and two or more Dependents	\$1,492.11

Other Southern California counties pricing area. If you live or work in these counties: Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, Riverside, San Diego, San Luis Obispo, Santa Barbara, and Tulare, the monthly Premiums are:

Other Southern California counties	Monthly Premiums
Self only	\$599.54
Self and one Dependent	\$1,199.08
Self and two or more Dependents	\$1,558.80

Out of State pricing area. If you live or work outside California, the monthly Premiums are:

Out of State	Monthly Premiums
Self only	\$940.67
Self and one Dependent	\$1,881.34
Self and two or more Dependents	\$2,445.74

Eligibility

Information pertaining to eligibility, enrollment, termination of coverage, and conversion rights can be obtained through the CalPERS website at www.calpers.ca.gov, or by calling CalPERS. Also, please refer to the CalPERS Health Program Guide for additional information about eligibility. Your coverage begins on the date established by CalPERS.

It is your responsibility to stay informed about your coverage. For an explanation of specific enrollment and eligibility criteria, please consult your Health Benefits Officer or, if you are retired, the CalPERS Member Account Management Division at:

CalPERS
Member Account Management Division
P.O. Box 942714
Sacramento, CA 94229-2714

Or call:

888 CalPERS (or **888-225-7377**)
(916) 795-3240 (TDD)

Health Plan eligibility requirements

We will ask CalPERS to approve termination of your membership in accord with Section 22841 of the California Government Code, if you commit any of the following acts:

- Your behavior threatens the safety of Plan personnel or of any person or property at a Plan Facility
- You commit theft from Health Plan, from a Plan Provider, or at a Plan Facility

If CalPERS approves termination of your membership, CalPERS will send written notice to the Subscriber.

Live/Work

If you are an active employee or a working CalPERS retiree, you may enroll in a plan using either your residential or work ZIP Code. When you retire from a CalPERS employer and are no longer working for any employer, you must select a health plan using your residential ZIP Code.

If you use your residential ZIP Code, all enrolled dependents must reside inside your Home Region Service Area. When you use your work ZIP Code, all enrolled dependents must receive all covered services (except emergency and urgent care) inside your Home Region Service Area, even if they do not reside in that Service Area.

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 your Home Region 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
- Chiropractic and acupuncture services as described in the "ASH Plans Combined Chiropractic and Acupuncture Services" section
- Durable medical equipment as described under "Durable Medical Equipment for Home Use" in the "Benefits, Copayments, and Coinsurance" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits, Copayments, and Coinsurance" section

- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Home health care as described under "Home Health Care" in the "Benefits, Copayments, and Coinsurance" section
- Hospice care as described under "Hospice Care" in the "Benefits, Copayments, and Coinsurance" section
- Visiting Member Services as described under "Receiving Care in the Service Area of another Region" in the "How to Obtain Services" section
- Ostomy and urological supplies as described under "Ostomy and Urological Supplies" in the "Benefits, Copayments, and Coinsurance" section
- Prosthetics and orthotics as described under "Prosthetic and Orthotic Devices" in the "Benefits, Copayments, and Coinsurance" section

As a Member, you are enrolled in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), called your Home Region. The coverage information in this *Evidence of Coverage* applies when you obtain care in your Home Region.

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 this *Evidence of Coverage*.

Routine Care

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

- Preventive Services
- 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 or you are outside your Home Region Service Area

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. However, if you choose a specialist who is not designated as a Primary

Care Physician as your personal Plan Physician, the Copayment or Coinsurance for a Physician Specialist Visit will apply to all visits with the specialist except for routine preventive visits listed under "Preventive Services" in the "Benefits, Copayments, and Coinsurance" section.

To learn how to select or change to a different personal Plan Physician, please refer to *Your Guidebook* or call our Member Service Contact 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 at any time 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. Also, a Plan Physician must refer you before you can get care from Qualified Autism Service Providers covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the "Benefits, Copayments, and Coinsurance" section. However, you do not need a referral or prior authorization to receive most care from any of the following Plan Providers:

- 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 most care from these providers, a referral may be required in the following situations:

- 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
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition

Standing referrals

If a Plan Physician refers you to a specialist, the referral will be for a specific treatment plan. Your treatment plan may include a standing referral if ongoing care from the

specialist is prescribed. For example, if you have a life-threatening, degenerative, or disabling condition, you can get a standing referral to a specialist if ongoing care from the specialist is required.

Medical Group authorization procedure for certain referrals

The following are examples of Services that 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
- Ostomy and urological supplies
- Services not available from Plan Providers
- Transplants

Utilization Management (UM) is a process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UM process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at kp.org/UM or call our Member Service Contact 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.

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 of 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. 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.

If the Medical Group does not authorize all of the Services requested and you want to appeal the decision, you can file a grievance as described under "Grievances" in the "Dispute Resolution" section.

Your Copayment or Coinsurance. Your Copayment or Coinsurance for these referral Services are the Copayments or Coinsurance required for Services provided by a Plan Provider as described in this *Evidence of Coverage*.

Completion of Services from Non-Plan Providers

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

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

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

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration. We may cover these Services until the acute condition ends
- Serious chronic conditions until the earlier of (1) 12 months from your effective date of coverage if you are a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the

first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non-Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:

- ◆ it persists without full cure
- ◆ it worsens over an extended period of time
- ◆ it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Children under age 3. We may cover completion of these Services until the earlier of (1) 12 months from the child's effective date of coverage if the child is a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the child's third birthday
- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of your effective date of coverage if you are a new Member or within 180 days of the termination date of the terminated provider

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

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

Region Service Area (the requirement that the provider agree to providing Services inside your Home Region Service Area doesn't apply if you were receiving covered Services from the provider outside the Service Area when the provider's contract terminated)

- The Services to be provided to you would be covered Services under this *Evidence of Coverage* if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from your effective date of coverage if you are a new Member or from the termination date of the Plan Provider

Your Copayment or Coinsurance. Your Copayment or Coinsurance for completion of Services are the Copayments or Coinsurance required for Services provided by a Plan Provider as described in this *Evidence of Coverage*.

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 Contact Center.

Second Opinions

If you want a second opinion, you can ask your Member Services to help you arrange one with a Plan Physician who is an appropriately qualified medical professional for your condition. If there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, Member Services will help you arrange a consultation with a Non-Plan Physician for a second opinion. For purposes of this "Second Opinions" provision, an "appropriately qualified medical professional" is a physician who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the illness or condition associated with the request for a second medical opinion.

Here are some examples of when a second opinion may be provided or authorized:

- 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 have a right to a second opinion. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial and of your right to file a grievance as described under "Grievances" in the "Dispute Resolution" section.

Your Copayment or Coinsurance. Your Copayment or Coinsurance for these referral Services are the Copayments or Coinsurance required for Services provided by a Plan Provider as described in this *Evidence of Coverage*.

Interactive Video Visits

Interactive video visits between you and your provider are intended to make it more convenient for you to receive covered Services, when a Plan Provider determines it is medically appropriate for your medical condition. You may receive covered Services via interactive video visits, when available and if the Services would have been covered under "this *Evidence of Coverage* if provided in person. You are not required to use interactive video visits. If you do agree to use interactive video visits, you may be charged Copayment or Coinsurance for the Services you receive. (For example, if you have an interactive video visit consultation with a specialist, you may be charged the Copayment or Coinsurance for a Physician Specialist Visit.)

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 visit our website at kp.org or call our Member Service Contact Center.

Financial liability

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

Termination of a Plan Provider's contract

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

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

Receiving Care in the Service Area of another Region

If you are visiting in the service area of another Region, you may receive Visiting Member Services from designated providers in that Region. "Visiting Member Services" are Services that are covered under your Home Region plan that you receive in another Region, subject to exclusions, limitations, and reductions described in this *EOC* or the Visiting Member Brochure, which is available online at kp.org. For more information about receiving Visiting Member Services in other Regions, including limits on the availability of Visiting Member Services, prior authorization or approval requirements, and provider and facility locations, or to obtain a copy of the Visiting Member Brochure, please call our Away from Home Travel Line at **951-268-3900**. Information is also available online at kp.org/travel.

Your Copayment or Coinsurance. Your Copayment or Coinsurance for Visiting Member Services is **the Copayment or Coinsurance required for Services provided by a Plan Provider inside your Home Region Service Area** as described in this *EOC*.

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 Contact 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 will submit the matter to CalPERS for appropriate action 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

Many 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 Contact Center representatives are available to assist you toll free 24 hours a day, seven days a week (except closed holidays) as follows:

- English: **1-800-464-4000**
- Spanish: **1-800-788-0616**
- Chinese dialects: **1-800-757-7585**
- TTY for the deaf, hard of hearing, or speech impaired: **711**

For your convenience, you can also contact us through our website at **kp.org**.

Member Services representatives at our Plan Facilities and Member Service Contact 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, including sign language, are available during all business hours at no cost to you. For more information on the interpreter services we offer, please call our Member Service Contact Center.

Plan Facilities

Plan Medical Offices and Plan Hospitals for your area are listed in *Your Guidebook to Kaiser Permanente Services (Your Guidebook)* and on our website at **kp.org**. *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. 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. If you have any questions about the current locations of Plan Medical Offices and/or Plan Hospitals, please call our Member Service Contact Center.

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)
- Most Plan Medical Offices include pharmacy Services

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 Contact Center, to ensure that you can obtain the health care services that you need.

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

Emergency 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.

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 in a hospital (including the Emergency Department) after your treating physician determines that this condition is Stabilized. We cover Post-Stabilization Care from a Non-Plan Provider 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 prior authorization, the provider must call **1-800-225-8883** or the notification telephone number on your Kaiser Permanente ID card *before* you receive the care. We will discuss your condition with the Non-Plan

Provider. If we determine that you require Post-Stabilization Care and that this care is part of your covered benefits, 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. If you receive care from a Non-Plan Provider that we have not authorized, you may have to pay the full cost of that care. If you are admitted to a Non-Plan Hospital, please notify us as soon as possible by calling **1-800-225-8883** or the notification telephone number on your Kaiser Permanente ID card.

Your Copayment or Coinsurance

Your Copayment or Coinsurance for covered Emergency Services and Post-Stabilization Care is described in the "Benefits, Copayments, and Coinsurance" section. Your Copayment or Coinsurance is the same where you receive the Services from a Plan Provider or Non-Plan Provider. For example:

- If you receive Emergency Services in the Emergency Department of a Non-Plan Hospital, you pay the Copayment or Coinsurance for an Emergency Department visit as described under "Outpatient Care"
- If we gave prior authorization for inpatient Post-Stabilization Care in a Non-Plan Hospital, you pay the Copayment or Coinsurance for hospital inpatient care as described under "Hospital Inpatient Care"

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 need Urgent Care 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 your Home Region Service Area
- A reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to your Home Region 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 if the Services would have been covered under "this *Evidence of Coverage* if you had received them from Plan Providers.

We do not cover follow-up care from Non-Plan Providers after you no longer need Urgent Care. To obtain follow-up care from a Plan Provider, call the appointment or advice telephone number listed in *Your Guidebook*.

Your Copayment or Coinsurance

Your Copayment or Coinsurance for covered Urgent Care is the Copayment or Coinsurance required for Services provided by Plan Providers as described in this *Evidence of Coverage*. For example:

- If you receive an Urgent Care evaluation as part of covered Out-of-Area Urgent Care from a Non-Plan Provider, you pay the Copayment or Coinsurance for Urgent Care consultations, evaluations, and treatment as described under "Outpatient Care"
- If the Out-of-Area Urgent Care you receive includes an X-ray, you pay the Copayment or Coinsurance for an X-ray as described under "Outpatient Imaging, Laboratory, and Special Procedures" in addition to the Copayment or Coinsurance for the Urgent Care evaluation

Note: If you receive Urgent Care in an Emergency Department, you pay the Copayment or Coinsurance for an Emergency Department visit as described under "Outpatient Care."

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, Copayments, and Coinsurance" section, you are not responsible for any amounts beyond your Copayment or Coinsurance for covered Emergency Services. However,

if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. 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.

For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Benefits, Copayments, and Coinsurance

We cover the Services described in this "Benefits, Copayments, and Coinsurance" 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:
 - ◆ Preventive Services
 - ◆ health care items and services for diagnosis, assessment, or treatment
 - ◆ health education covered under "Health Education" in this "Benefits, Copayments, and Coinsurance" 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:
 - ◆ chiropractic and acupuncture services as described in the "ASH Plans Combined Chiropractic and Acupuncture Services" section
 - ◆ drugs prescribed by dentists as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits, Copayments, and Coinsurance" section
 - ◆ emergency ambulance Services as described under "Ambulance Services" in this "Benefits, Copayments, and Coinsurance" section
 - ◆ Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
 - ◆ eyeglasses and contact lenses following cataract surgery prescribed by Non-Plan Providers as described under "Vision Services for Adult

Members" and "Vision Services for Pediatric Members" in this "Benefits, Copayments, and Coinsurance" section

- ◆ Visiting Member Services as described under "Receiving Care in the Service Area of another Region" in the "How to Obtain Services" section
- You receive the Services from Plan Providers inside your Home Region 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
 - ◆ chiropractic and acupuncture services as described in the "ASH Plans Combined Chiropractic and Acupuncture Services" section
 - ◆ durable medical equipment as described under "Durable Medical Equipment for Home Use" in the "Benefits, Copayments, and Coinsurance" section
 - ◆ emergency ambulance Services as described under "Ambulance Services" in this "Benefits, Copayments, and Coinsurance" section
 - ◆ Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
 - ◆ home health care as described under "Home Health Care" in this "Benefits, Copayments, and Coinsurance" section
 - ◆ hospice care as described under "Hospice Care" in this "Benefits, Copayments, and Coinsurance" section
 - ◆ ostomy and urological supplies as described under "Ostomy and Urological Supplies" in the "Benefits, Copayments, and Coinsurance" section
 - ◆ prosthetics and orthotics as described under "Prosthetic and Orthotic Devices" in the "Benefits, Copayments, and Coinsurance" section
 - ◆ Visiting Member Services as described under "Receiving Care in the Service Area of another Region" in the "How to Obtain Services" 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 *Evidence of Coverage* are those that this *Evidence of Coverage* says that we cover, subject to exclusions and limitations described in this *Evidence of Coverage* 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 *Evidence of Coverage*. 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

Your Copayment and Coinsurance

Your Copayments and Coinsurance are the amounts you are required to pay for covered Services. The Copayment or Coinsurance for covered Services is listed in this *Evidence of Coverage*. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Copayment or Coinsurance for those Services will be Charges until you reach the Plan Deductible.

General rules, examples, and exceptions

Your Copayment or Coinsurance for covered Services will be the Copayment or Coinsurance in effect on the date you receive the Services, except as follows:

- If you are receiving covered inpatient hospital or Skilled Nursing Facility Services on the effective date of this *Evidence of Coverage*, you pay the Copayment or Coinsurance 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 Copayment or Coinsurance in effect on the date you receive the Services
- For items ordered in advance, you pay the Copayment or Coinsurance in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Copayment or Coinsurance 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

Copayment and Coinsurance for Services received by newborn children of a Member. During the 31 days of

automatic coverage for newborn children the parent or guardian of the newborn must pay the Copayment or Coinsurance indicated in this "Benefits, Copayment and Coinsurance" section for any Services that the newborn receives, whether or not the newborn is enrolled.

Payment toward your Copayment or Coinsurance (and when you may be billed). In most cases, your provider will ask you to make a payment toward your Copayment or Coinsurance at the time you receive Services. If you receive more than one type of Services (such as a routine physical maintenance exam and laboratory tests), you may be required to pay separate Copayment or Coinsurance for each of those Services. Keep in mind that your payment toward your Copayment or Coinsurance may cover only a portion of your total Copayment or Coinsurance for the Services you receive, and you will be billed for any additional amounts that are due. The following are examples of when you may be asked to pay (or you may be billed for) Copayment or Coinsurance amounts in addition to the amount you pay at check-in:

- You receive non-preventive Services during a preventive visit. For example, you go in for a routine physical maintenance exam, and at check-in you pay your Copayment or Coinsurance for the preventive exam (your Copayment or Coinsurance may be "no charge"). However, during your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory tests). You may be asked to pay (or you will be billed for) your Copayment or Coinsurance for these additional non-preventive diagnostic Services
- You receive diagnostic Services during a treatment visit. For example, you go in for treatment of an existing health condition, and at check-in you pay your Copayment or Coinsurance for a treatment visit. However, during the visit your provider finds a new problem with your health and performs or orders diagnostic Services (such as laboratory tests). You may be asked to pay (or you will be billed for) your Copayment or Coinsurance for these additional diagnostic Services
- You receive treatment Services during a diagnostic visit. For example, you go in for a diagnostic exam, and at check-in you pay your Copayment or Coinsurance for a diagnostic exam. However, during the diagnostic exam your provider confirms a problem with your health and performs treatment Services (such as an outpatient procedure). You may be asked to pay (or you will be billed for) your Copayment or Coinsurance for these additional treatment Services

- You receive Services from a second provider during your visit. For example, you go in for a diagnostic exam, and at check-in you pay your Copayment or Coinsurance for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay (or you will be billed for) your Copayment or Coinsurance for the consultation with the specialist

In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for your Copayment or Coinsurance. The following are examples of when you will be billed:

- A Plan Provider is not able to collect Copayment or Coinsurance at the time you receive Services (for example, some Laboratory Departments are not able to collect Copayment or Coinsurance)
- You ask to be billed for some or all of your Copayment or Coinsurance
- Medical Group authorizes a referral to a Non-Plan Provider and that provider does not collect your Copayment or Coinsurance at the time you receive Services
- You receive covered Emergency Services or Out-of-Area Urgent Care from a Non-Plan Provider and that provider does not collect your Copayment or Coinsurance at the time you receive Services

If you have questions about a bill, please call the phone number on the bill.

Infertility Services. Before starting or continuing a course of infertility Services, you may be required to pay initial and subsequent deposits toward your Copayment or Coinsurance for some or all of the entire course of Services, along with any past-due infertility-related Copayment or Coinsurance. Any unused portion of your deposit will be returned to you. When a deposit is not required, you must pay the Copayment or Coinsurance for the procedure, along with any past-due infertility-related Copayment or Coinsurance, before you can schedule an infertility procedure.

Primary Care Visits, Non-Physician Specialist Visits, and Physician Specialist Visits. The Copayment or Coinsurance for a Primary Care Visit applies to evaluations and treatment provided by generalists in internal medicine, pediatrics, or family practice, and by specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Some physician specialists provide primary care in addition to specialty care but are not designated as Primary Care Physicians. If you receive Services from one of these specialists, the Copayment or Coinsurance for a

Physician Specialist Visit will apply to all consultations, evaluations, and treatment provided by the specialist except for routine preventive counseling and exams listed under "Preventive Services" in this "Benefits, Copayments, and Coinsurance" section. For example, if your personal Plan Physician is a specialist in internal medicine or obstetrics/gynecology who is not a Primary Care Physician, you will pay the Copayment or Coinsurance for a Physician Specialist Visit for all consultations, evaluations, and treatment by the specialist except routine preventive counseling and exams listed under "Preventive Services" in this "Benefits, Copayments, and Coinsurance" section. The Non-Physician Specialist Visit Copayment or Coinsurance applies to consultations, evaluations, and treatment provided by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

Noncovered Services. If you receive Services that are not covered under this *Evidence of Coverage*, you may have to pay the full price of those Services. Payments you make for noncovered Services do not apply to any deductible or out-of-pocket maximum.

Getting an estimate of your Copayment or Coinsurance

If you have questions about the Copayment or Coinsurance for specific Services that you expect to receive or that your provider orders during a visit or procedure, please visit our website at kp.org/memberestimates to use our cost estimate tool or call our Member Service Contact Center.

- If you have a Plan Deductible and would like an estimate for Services that are subject to the Plan Deductible, please call weekdays 7 a.m. to 5 p.m. toll free at 1-800-390-3507 (TTY users call 711)
- For all other Copayment or Coinsurance estimates, please call 1-800-464-4000 (TTY users call 711)

Copayment or Coinsurance estimates are based on your benefits and the Services you expect to receive. They are a prediction of cost and not a guarantee of the final cost of Services. Your final cost may be higher or lower than the estimate since not everything about your care can be known in advance.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service, after you meet any applicable deductible, is described in this *Evidence of Coverage*.

Drug out-of-pocket maximum

Please refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits, Copayments, and

Coinsurance" section for Services that are subject to the outpatient prescription drug maximum and the maximum amount.

Plan Out-of-Pocket Maximum

There is a limit to the total amount of Copayment or Coinsurance you must pay under this *Evidence of Coverage* in the calendar year for covered Services that you receive in the same calendar year. The Services that apply to the Plan Out-of-Pocket Maximum are described under the "Payments that count toward the Plan Out-of-Pocket Maximum" section below. The limit is one of the following amounts:

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

If you are a Member in a Family of two or more Members, you reach the Plan Out-of-Pocket Maximum either when you reach the maximum for any one Member, or when your Family reaches the Family maximum. For example, suppose you have reached the **\$1,500** maximum for any one Member. For Services subject to the Plan Out-of-Pocket Maximum, you will not pay any more Copayments or Coinsurance during the remainder of the calendar year, but every other Member in your Family must continue to pay Copayments or Coinsurance during the remainder of the calendar year until either he or she reaches the **\$1,500** maximum for any one Member or your Family reaches the **\$3,000** Family maximum.

Payments that count toward the Plan Out-of-Pocket Maximum. Any payments you make toward the Plan Deductible, if applicable, apply toward the maximum.

Also, Copayments and Coinsurance you pay for covered Services apply to the maximum, except as described below:

- In the "Durable Medical Equipment for Home Use" section, Copayments and Coinsurance for items described under "Durable medical equipment that are not essential health benefits" do not apply toward the maximum
- In the "Infertility Services" section, Copayments and Coinsurance for all Services do not apply toward the maximum
- In the "Outpatient Prescription Drugs, Supplies, and Supplements" section, Copayments and Coinsurance

for only the following items apply toward the maximum:

- ◆ diabetes supplies
- ◆ amino-acid modified products
- In the "Vision Services for Adult Members" section, Copayments and Coinsurance for Services described under "Low vision devices" do not apply toward the maximum
- If your plan includes supplemental chiropractic or acupuncture Services described in an Amendment to this *Evidence of Coverage*, those Services will not apply toward the maximum
- If your plan includes an Allowance for specific Services (such as eyeglasses, contact lenses, or hearing aids), any amounts you pay that exceed the Allowance do not apply toward the maximum

If your plan includes pediatric dental Services described in a Pediatric Dental Services Amendment to this *Evidence of Coverage*, those Services will apply toward the maximum.

Keeping track of the Plan Out-of-Pocket Maximum.

When you receive Services, we will give you a receipt that shows how much you paid. To see how close you are to reaching your Plan Out-of-Pocket Maximum, use our online Out-of-Pocket Summary tool at kp.org/outofpocket or call our Member Service Contact Center.

Outpatient Care

We cover the following outpatient care subject to the Copayment or Coinsurance indicated:

- Primary Care Visits for evaluations and treatment and Non-Physician Specialist Visits for consultations, evaluations, and treatment, other than those described below in this "Outpatient Care" section: **a \$15 Copayment per visit**
- Physician Specialist Visits for consultations, evaluations, and treatment other than those described below in this "Outpatient Care" section: **a \$15 Copayment per visit**
- The first postpartum follow-up consultation and exam: **no charge**
- Allergy injections (including allergy serum): **no charge**
- Outpatient surgery and outpatient procedures when 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: **a \$15 Copayment per procedure**

- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a \$15 Copayment per procedure**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Copayment or Coinsurance that would otherwise apply for the procedure** in this "Benefits, Copayments, and Coinsurance" 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")
- Urgent Care consultations, evaluations, and treatment: **a \$15 Copayment per visit**
- Emergency Department visits: **a \$50 Copayment per visit**. The Emergency Department Copayment does not apply if you are admitted directly to the hospital as an inpatient for covered Services or if you are admitted for observation in a hospital unit outside the Emergency Department
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside your Home Region Service Area when care can best be provided in your home as determined by a Plan Physician: **no charge**
- Acupuncture Services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain):
 - ◆ acupuncture Services provided by a Non-Physician Specialist: **a \$15 Copayment per visit**
 - ◆ acupuncture Services provided by a Physician Specialist: **a \$15 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:
 - ◆ tuberculosis skin tests: **no charge**
 - ◆ administered chemotherapy drugs: **no charge**
 - ◆ all other administered drugs: **no charge**
- Outpatient consultations, evaluations, and treatment that are available as group appointments: **a \$7 Copayment per visit**

Coverage for Services related to "Outpatient Care" described in other sections

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

- Bariatric Surgery
- Behavioral Health Treatment for Pervasive Developmental Disorder or Autism
- Chemical Dependency Services
- Dental and Orthodontic Services
- Dialysis Care
- Durable Medical Equipment for Home Use
- Family Planning Services
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Infertility Services
- Mental Health Services
- Ostomy and Urological Supplies
- Outpatient Imaging, Laboratory, and Special Procedures
- Outpatient Prescription Drugs, Supplies, and Supplements
- Preventive Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Rehabilitative and Habilitative Services
- Services in Connection with a Clinical Trial
- Transplant Services
- Vision Services for Adult Members
- Vision Services for Pediatric Members

Hospital Inpatient Care

We cover the following inpatient Services at **no charge** in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals inside your Home Region 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, Copayments, and Coinsurance" section)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and special procedures
- Blood, blood products, and their administration
- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge (for visits after you are released from the hospital, please refer to "Outpatient Care" in this "Benefits, Copayments, and Coinsurance" section)
- Behavioral health treatment for pervasive developmental disorder or autism
- Respiratory therapy
- Medical social services and discharge planning

Coverage for Services related to "Hospital Inpatient Care" described in other sections

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

- Bariatric Surgery
- Chemical Dependency Services
- Dental and Orthodontic Services
- Dialysis Care
- Hospice Care
- Infertility Services
- Mental Health Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Rehabilitative and Habilitative Services
- Services in Connection with a Clinical Trial
- Skilled Nursing Facility Care
- Transplant Services

Ambulance Services

Emergency

We cover at **no charge** Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

- A reasonable person would have believed that the medical condition was an Emergency Medical Condition which required ambulance 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 are not responsible for any amounts beyond your Copayment or Coinsurance for covered emergency ambulance Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Nonemergency

Inside your Home Region Service Area, we cover nonemergency ambulance and psychiatric transport van Services at **no charge** if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to or from covered Services.

Ambulance Services exclusion(s)

- 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 **Copayment or Coinsurance you would pay if the Services were not related to a bariatric surgical procedure**. For example, see "Hospital Inpatient Care" in this "Benefits, Copayments, and Coinsurance" section for the Copayment or Coinsurance that applies for hospital inpatient care.

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 offered by your Group
- 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 offered by your Group
- 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 offered by your Group
- 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 offered by your Group

Coverage for Services related to "Bariatric Surgery" described in other sections

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

Behavioral Health Treatment for Pervasive Developmental Disorder or Autism

The following terms have special meaning when capitalized and used in this "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" section:

- "Qualified Autism Service Provider" means a provider who has the experience and competence to design, supervise, provide, or administer treatment for pervasive developmental disorder or autism and is either of the following:
 - ◆ a person, entity, or group that is certified by a national entity (such as the Behavior Analyst Certification Board) that is accredited by the National Commission for Certifying Agencies
 - ◆ a person licensed in California as a physician, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist
- "Qualified Autism Service Professional" means a person who meets all of the following criteria:
 - ◆ provides behavioral health treatment
 - ◆ is employed and supervised by a Qualified Autism Service Provider
 - ◆ provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
 - ◆ is a behavioral health treatment provider approved as a vendor by a California regional center to provide Services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations
 - ◆ has training and experience in providing Services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code

- "Qualified Autism Service Paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:
 - ◆ is employed and supervised by a Qualified Autism Service Provider
 - ◆ provides treatment and implements Services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
 - ◆ meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code
 - ◆ has adequate education, training, and experience, as certified by a Qualified Autism Service Provider

We cover behavioral health treatment for pervasive developmental disorder or autism (including applied behavior analysis and evidence-based behavior intervention programs) that develops or restores, to the maximum extent practicable, the functioning of a person with pervasive developmental disorder or autism and that meet all of the following criteria:

- The Services are provided inside your Home Region Service Area
- The treatment is prescribed by a Plan Physician, or is developed by a Plan Provider who is a psychologist
- The treatment is provided under a treatment plan prescribed by a Plan Provider who is a Qualified Autism Service Provider
- The treatment is administered by a Plan Provider who is one of the following:
 - ◆ a Qualified Autism Service Provider
 - ◆ a Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider
 - ◆ a Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service Provider
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the Member being treated
- The treatment plan is reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate
- The treatment plan requires the Qualified Autism Service Provider to do all of the following:
 - ◆ Describe the Member's behavioral health impairments to be treated

- ◆ Design an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member's progress is evaluated and reported
- ◆ Provide intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism
- ◆ Discontinue intensive behavioral intervention Services when the treatment goals and objectives are achieved or no longer appropriate
- The treatment plan is not used for either of the following:
 - ◆ for purposes of providing (or for the reimbursement of) respite care, day care, or educational services
 - ◆ to reimburse a parent for participating in the treatment program

You pay the following for these covered Services:

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

Effective as of the date that federal proposed final rulemaking for essential health benefits is issued, we will cover Services under this "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" section only if they are included in the essential health benefits that all health plans will be required by federal regulations to provide under section 1302(b) of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act.

Chemical Dependency Services

Outpatient chemical dependency care

We cover the following Services for treatment of chemical dependency:

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

You pay the following for these covered Services:

- Individual chemical dependency evaluation and treatment: **a \$15 Copayment per visit**
- Group chemical dependency treatment: **a \$5 Copayment per visit**

- Intensive outpatient and day-treatment programs: **a \$5 Copayment per day**

Residential treatment

Inside your Home Region Service Area, we cover the following Services at **no charge** when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized chemical dependency treatment, the Services are generally and customarily provided by a chemical dependency residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group chemical dependency counseling
- Medical services
- Medication monitoring
- Room and board
- Social services
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, please refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits, Copayments, and Coinsurance" section)
- Discharge planning

Inpatient detoxification

We cover hospitalization 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. We cover these Services at **no charge**.

Coverage for Services related to "Chemical Dependency Services" described in other sections

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

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 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.

Accidental injury to teeth

Services for accidental injury to teeth are not covered.

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, Copayments, and Coinsurance" section ("cleft palate" includes cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate)
- 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)

Your Copayment or Coinsurance for dental and orthodontic Services

You pay the following for dental and orthodontic Services covered under this "Dental and Orthodontic Services" section:

- Primary Care Visits for evaluations and treatment and Non-Physician Specialist Visits (including visits with dentists and orthodontists for Services covered under

this "Dental and Orthodontic Services" section) for consultations, evaluations, and treatment: **a \$15 Copayment per visit**

- Physician Specialist Visits for consultations, evaluations, and treatment: **a \$15 Copayment per visit**
- Outpatient surgery and other outpatient procedures when 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: **a \$15 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a \$15 Copayment per procedure**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Copayment or Coinsurance that would otherwise apply for the procedure** in this "Benefits, Copayments, and Coinsurance" 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")
- Hospital inpatient care (including room and board, drugs, imaging, laboratory, special procedures, and Plan Physician Services): **no charge**

Coverage for Services related to "Dental and Orthodontic Services" described in other sections

- 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 your Home Region 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 your Home Region 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:

- One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment: **no charge**
- Hemodialysis treatment at a Plan Facility: **no charge**
- All other Primary Care Visits for evaluations and treatment and Non-Physician Specialist Visits for consultations, evaluations, and treatment: **a \$15 Copayment per visit**
- All other Physician Specialist Visits for consultations, evaluations, and treatment: **a \$15 Copayment per visit**
- Inpatient dialysis care: **no charge**

Coverage for Services related to "Dialysis Care" described in other sections

- 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 exclusion(s)

- 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

For Members who live inside California, we cover durable medical equipment for use in your home (or another location used as your home) in accord with our durable medical equipment formulary guidelines. Durable medical equipment for home use is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.

Durable medical equipment items that are essential health benefits

Inside your Home Region Service Area, we cover the following durable medical equipment (including repair or replacement of covered equipment) at **no charge**:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Bone stimulator
- Canes (standard curved handle or quad) and replacement supplies
- Cervical traction (over door)
- Crutches (standard or forearm) and replacement supplies
- Dry pressure pad for a mattress
- Enteral pump and supplies
- Infusion pumps (such as insulin pumps) and supplies to operate the pump
- IV pole
- Nebulizer and supplies
- Peak flow meters
- Phototherapy blankets for treatment of jaundice in newborns
- Tracheostomy tube and supplies

Breastfeeding supplies

We cover at **no charge** one retail-grade breast pump per pregnancy and the necessary supplies to operate it, such as one set of bottles. We will decide whether to rent or purchase the item and we choose the vendor. We cover this pump for convenience purposes. The pump is not

subject to prior authorization requirements or the formulary guidelines.

Inside your Home Region Service Area, if you or your baby has a medical condition that requires the use of a breast pump, we cover at **no charge** a hospital-grade breast pump and the necessary supplies to operate it, in accord with our durable medical equipment formulary guidelines. We will determine whether to rent or purchase the equipment and we choose the vendor. Hospital-grade breast pumps on our formulary are subject to the durable medical equipment prior authorization requirements as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section. For more information about our durable medical equipment formulary, see the "About our durable medical equipment formulary" in this "Durable Medical Equipment for Home Use" section.

Durable medical equipment items that are not essential health benefits

For all other covered durable medical equipment, you pay the following (including repair or replacement of covered equipment):

- External sexual dysfunction devices: **no charge**
- All other covered durable medical equipment: **no charge**

Outside California

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

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices) from a Plan Pharmacy
- Canes (standard curved handle)
- Crutches (standard)
- Insulin pumps and supplies to operate the pump, after completion of training and education on the use of the pump
- Nebulizers and their supplies for the treatment of pediatric asthma
- Peak flow meters from a Plan Pharmacy

About our durable medical equipment formulary

Our durable medical equipment formulary includes the list of durable medical equipment that has been approved

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

Our formulary guidelines allow you to obtain non-formulary 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.

Coverage for Services related to "Durable Medical Equipment for Home Use" described in other sections

- 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")
- Insulin and any other drugs administered with an infusion pump (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Durable medical equipment for home use exclusion(s)

- Comfort, convenience, or luxury equipment or features except for retail-grade breast pumps as described under "Breastfeeding supplies" in this "Durable Medical Equipment for Home Use" section
- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including devices intended to provide additional support for

recreational or sports activities) and hygiene equipment

- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies)
- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to loss or misuse

Family Planning Services

We cover the following family planning Services subject to the Copayment or Coinsurance indicated:

- Family planning counseling: **no charge**
- Internally implanted time-release contraceptives or intrauterine devices (IUDs) and office visits related to their administration and management: **no charge**
- Female sterilization procedures if provided in an outpatient or ambulatory surgery center or in a hospital operating room: **no charge**
- All other female sterilization procedures: **no charge**
- Male sterilization procedures if provided in an outpatient or ambulatory surgery center or in a hospital operating room: **a \$15 Copayment per procedure**
- All other male sterilization procedures: **a \$15 Copayment per visit**
- Termination of pregnancy: **a \$15 Copayment per procedure**

Coverage for Services related to "Family Planning Services" described in other sections

- Services to diagnose or treat infertility (refer to "Infertility Services")
- Outpatient administered drugs (refer to "Outpatient Care")
- Outpatient laboratory and imaging services associated with family planning services (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient contraceptive drugs and devices (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Family Planning Services exclusion(s)

- Reversal of voluntary sterilization

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 *Evidence of Coverage*.

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 a Health Education Department or our Member Service Contact Center, refer to *Your Guidebook*, or go to our website at **kp.org**.

You pay the following for these covered Services:

- Covered health education programs, which may include programs provided online and counseling over the phone: **no charge**
- Individual counseling during an office visit related to smoking cessation: **no charge**
- Individual counseling during an office visit related to diabetes management: **no charge**
- Other covered individual counseling when the office visit is solely for health education: **no charge**
- Health education provided during an outpatient consultation or evaluation covered in another part of this *Evidence of Coverage*: **no additional Copayment or Coinsurance beyond the Copayment or Coinsurance required in that other part of this Evidence of Coverage**
- Covered health education materials: **no charge**

Hearing Services

We cover the following:

- Hearing exams to determine the need for hearing correction: **no charge**
- Hearing tests to determine the appropriate hearing aid: **no charge**
- A **\$1,000 Allowance** toward the purchase price of hearing aid(s) every 36 months when prescribed by a Plan Physician or by a Plan Provider who is an audiologist. We will cover hearing aids for both ears only if both aids are required to provide significant

improvement that is not obtainable with only one hearing aid. We will not provide the Allowance if we have provided an Allowance toward (or otherwise covered) a hearing aid for that same ear within the previous 36 months. Also, the Allowance can only be used at the initial point of sale. If you do not use all of your Allowance at the initial point of sale, you cannot use it later

- Consultations and exams to verify that the hearing aid conforms to the prescription: **no charge**
- Consultations and exams for fitting, counseling, adjustment, cleaning, and inspection after the warranty is exhausted: **no charge**

We select the provider or vendor that will furnish the covered hearing aid. Coverage is limited to the types and models of hearing aids furnished by the provider or vendor.

Coverage for Services related to "Hearing Services" described in other sections

- Routine hearing screenings when performed as part of a routine physical maintenance exam (refer to "Preventive Services")
- Services related to the ear or hearing other than those described in this section, such as outpatient care to treat an ear infection and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits, Copayments, and Coinsurance" section)
- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Hearing Services exclusion(s)

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

Home Health Care

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

- You are substantially confined to your home (or a friend's or relative's home)
- Your condition requires the Services of a nurse, physical therapist, 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 California

The Medical Group must authorize any home health nursing or other care of at least eight continuous hours, in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section (that authorization procedure does not apply to home health nursing or other care of less than eight continuous hours).

Coverage for Services related to "Home Health Care" described in other sections

- Behavioral health treatment for pervasive developmental disorder or autism (refer to "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism")
- Dialysis care (refer to "Dialysis Care")
- Durable medical equipment (refer to "Durable Medical Equipment for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Home health care exclusion(s)

- 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 your Home Region Service Area or inside California but within 15 miles or 30 minutes from your Home Region 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
- A Plan Physician determines that 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, 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 a Plan Pharmacy. Certain drugs are limited to a maximum 30-day supply in any 30-day period (please call our Member Service Contact 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

We also cover the following hospice Services only during periods of crisis when they are Medically Necessary to achieve palliation or management of acute medical symptoms:

- Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
- Short-term inpatient care required at a level that cannot be provided at home

Infertility Services

For purposes of this "Infertility Services" section, "infertility" means not being able to get pregnant or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception or having a medical or other demonstrated condition that is recognized by a Plan Physician as a cause of infertility.

Diagnosis and treatment of infertility

We cover the following Services related to infertility:

- Services for diagnosis and treatment of infertility
- Artificial insemination

You pay the following for covered infertility Services:

Service	Diagnosis, Treatment, and Artificial Insemination
Office visits	50% Coinsurance
Most outpatient surgery and outpatient procedures	50% Coinsurance
This Copayment or Coinsurance applies when the Services are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if the Services are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.	
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	50% Coinsurance
Outpatient imaging	50% Coinsurance

Service	Diagnosis, Treatment, and Artificial Insemination
Outpatient laboratory	50% Coinsurance
Outpatient special procedures	50% Coinsurance
Outpatient administered drugs	50% Coinsurance
Drugs prescribed in accord with our formulary guidelines if administration or observation by medical personnel is required and they are administered to you in a Plan Medical Office	
Hospital inpatient care (including room and board, drugs, imaging, laboratory, special procedures, and Plan Physician Services)	50% Coinsurance

GIFT, ZIFT, and IVF procedures

Services for assisted reproductive technologies such as invitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT) are not covered.

Coverage for Services related to "Infertility Services" described in other sections

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

Infertility Services exclusion(s)

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

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 identified as a "mental disorder" 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. We do not cover services for conditions that the *DSM* identifies as something other than a "mental disorder." For example, the *DSM* identifies relational problems as something other than a "mental disorder," so we do not cover services (such as couples counseling or family counseling) for relational problems.

"Mental Disorders" include the following conditions:

- Severe Mental Illness of a person of any age: "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, or bulimia nervosa
- A Serious Emotional Disturbance of a child under age 18. A "Serious Emotional Disturbance" of a child under age 18 means a condition identified as a "mental disorder" 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, (1) 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 (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
 - ♦ the child displays psychotic features, or risk of suicide or violence due to a mental disorder
 - ♦ the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

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:

- Individual and group mental health evaluation and treatment

- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient Services for the purpose of monitoring drug therapy

Intensive psychiatric treatment programs. We cover the following intensive psychiatric treatment programs at a Plan Facility:

- Partial hospitalization
- Multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Psychiatric observation for an acute psychiatric crisis

Your Copayment or Coinsurance. You pay the following for these covered Services:

- Individual mental health evaluation and treatment: **a \$15 Copayment per visit**
- Group mental health treatment: **a \$7 Copayment per visit**
- Intensive psychiatric treatment programs: **no charge**

Residential treatment

Inside your Home Region Service Area, we cover the following Services at **no charge** when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized mental health treatment, the Services are generally and customarily provided by a mental health residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group mental health evaluation and treatment
- Medical services
- Medication monitoring
- Room and board
- Social services
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, please refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits, Copayments, and Coinsurance" section)
- Discharge planning

Inpatient psychiatric hospitalization

We cover inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and

Services of Plan Physicians and other Plan Providers who are licensed health care professionals acting within the scope of their license. We cover these Services at **no charge**.

Coverage for Services related to "Mental Health Services" described in other sections

- 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

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 Durable Medical Equipment Formulary Executive Committee for our Members. Our Durable Medical Equipment 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 Contact Center.

Our formulary guidelines allow you to obtain non-formulary 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(s)

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Special Procedures

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

care covered under other headings in this "Benefits, Copayments, and Coinsurance" section:

- Certain outpatient imaging and laboratory Services are "Preventive Services". You can find more information about the "Preventive Services" we cover under "Preventive Services" in this "Benefits, Copayments, and Coinsurance" section
- All other CT scans, and all MRIs and PET scans: **no charge**
- All other imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds: **no charge** except that certain imaging procedures are covered at a **\$15 Copayment per procedure** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort
- Nuclear medicine: **no charge**
- Routine retinal photography screenings: **no charge**
- Laboratory tests to monitor the effectiveness of dialysis: **no charge**
- All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available): **no charge**
- All other diagnostic procedures provided by Plan Providers who are not physicians (such as EKGs and EEGs): **no charge** except that certain diagnostic procedures are covered at a **\$15 Copayment per procedure** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort
- Radiation therapy: **no charge**
- Ultraviolet light treatments: **no charge**

Coverage for Services related to "Outpatient Imaging, Laboratory, and Special Procedures" described in other sections

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

Outpatient Prescription Drugs, Supplies, and Supplements

Inside California, we cover outpatient drugs, supplies, and supplements specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section

when prescribed as follows and obtained at a Plan Pharmacy or through 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 items at a Plan Pharmacy or through our mail-order service unless you obtain the item as part of 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 at a Plan Pharmacy, through 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 a Plan Pharmacy if you have a question about whether your prescription can be mailed or obtained at a Plan Pharmacy. Items available through our mail-order service are subject to change at any time without notice.

Day supply limit

The prescribing physician or dentist determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, Plan Physicians

determine the amount of an item that constitutes a Medically Necessary 30- or 100-day supply for you. Upon payment of the Copayment or Coinsurance 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 one 30-day supply in a 30-day period or one 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 Copayment or Coinsurance 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 the drug formulary

The drug formulary includes a list of drugs that our Pharmacy and Therapeutics Committee has approved 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 at least quarterly to consider additions and deletions based on new information or drugs that become available. To find out which drugs are on the formulary for your plan, please visit our website at kp.org/formulary. If you would like to request a copy of the drug formulary for your plan, please call our Member Service Contact Center. Note: The presence of a drug on the drug formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition.

Drug formulary guidelines allow you to obtain non-formulary 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 non-formulary 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.

About specialty drugs

Specialty drugs are high-cost drugs that are on our specialty drug list. To obtain a list of specialty drugs that are on our formulary, or to find out if a non-formulary drug is on the specialty drug list, please call our Member Service Contact Center. If your Plan Physician prescribes more than a 30-day supply for an outpatient drug, you may be able to obtain more than a 30-day supply at one time, up to the day supply limit for that drug. However, most specialty drugs are limited to a 30-day supply in any 30-day period. Your Plan Pharmacy can tell you if a drug you take is one of these drugs.

General rules about coverage and your Copayment or Coinsurance

We cover the following outpatient drugs, supplies, and supplements as described in this "Outpatient Prescription Drugs, Supplies, and Supplements" section:

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

Note:

- If Charges for the drug, supply, or supplement are less than the Copayment, you will pay the lesser amount
- Items can change tier at any time, in accord with formulary guidelines, which may impact your Copayment or Coinsurance (for example, if a brand-name drug is added to the specialty drug list, you will pay the Copayment or Coinsurance that applies to drugs on the specialty drug tier, not the Copayment or Coinsurance for drugs on the brand-name drug tier)

Continuity drugs. If this *Evidence of Coverage* is amended to exclude a drug that we have been covering and providing to you under this *Evidence of Coverage*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration: **50% Coinsurance** for up to a 30-day supply in any 30-day period.

Mail order service. Prescription refills can be mailed within 7 to 10 days at no extra cost for standard U.S. postage. The appropriate Copayment or Coinsurance

(according to your drug coverage) will apply and must be charged to a valid credit card.

You may request mail order service in the following ways:

- To order online, visit kp.org/rxrefill (you can register for a secure account at kp.org/registernow) or use the kp.org app from your Web-enabled phone or mobile device
- Call the pharmacy phone number highlighted on your prescription label and select the mail delivery option
- On your next visit to a Kaiser Permanente pharmacy, ask our staff how you can have your prescriptions mailed to you

Note: Not all drugs can be mailed; restrictions and limitations apply.

Drug out-of-pocket maximum

There is a limit to the total amount of Copayments and Coinsurance you must pay under this *Evidence of Coverage* in a calendar year for covered outpatient prescription drugs, supplies, and supplements that you receive in the same calendar year. The Services that apply to the maximum are described under the "Payments that count toward the drug maximum" section below. The limit is one of the following amounts:

- **\$5,650** per calendar year for self-only enrollment (a Family of one Member)
- **\$5,650** per calendar year for any one Member in a Family of two or more Members
- **\$11,300** per calendar year for an entire Family of two or more Members

If you are a Member in a Family of two or more Members, you reach the outpatient prescription drug out-of-pocket maximum either when you meet the maximum for any one Member, or when your Family reaches the Family maximum. For example, suppose you have reached the \$5,650 maximum. For Services subject to the maximum, you will not pay any more Copayments or Coinsurance during the rest of the calendar year, but every other Member in your Family must continue to pay Copayments or Coinsurance during the calendar year until your Family reaches the \$11,300 maximum.

Payments that count toward the drug out-of-pocket maximum. Any Copayments and Coinsurance you pay for covered items under this "Outpatient Prescription Drugs, Supplies, and Supplements" section apply toward the drug maximum, except for the following:

- Drugs when prescribed for the treatment of infertility

- Insulin administration devices covered under "Diabetes urine-testing supplies and insulin-administration devices." These items apply to the Plan out-of-pocket maximum.
- Amino acid-modified products used to treat congenital errors of amino acid metabolism. These items apply to the Plan out-of-pocket maximum.

Keeping track of the drug out-of-pocket maximum.

When you meet your drug out-of-pocket maximum you will not have to pay any more Copayments or Coinsurance for covered outpatient prescription drugs, supplies, and supplements that apply to the drug out-of-pocket maximum for the rest of the calendar year.

Coverage and your Copayment or Coinsurance for most items

Drugs, supplies, and supplements are covered as follows except for items listed under "Other items:"

If your Plan Physician prescribes more than a 30-day supply for an outpatient drug, you may be able to obtain more than a 30-day supply at one time up to the day supply limit for that drug. Applicable Copayment or Coinsurance will apply. For example, two 30-day copayments may be due when picking up a 60-day prescription, three copayments may be due when picking up a 100-day prescription at the pharmacy.

Item	Your Copayment or Coinsurance	
	Plan Pharmacy	By Mail
Items on the generic tier	\$5 for up to a 30-day supply	\$10 for up to a 100-day supply
Items on the brand-name tier	\$20 for up to a 30-day supply	\$40 for up to a 100-day supply
Items on the specialty tier	\$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy

Other items

Coverage and your Copayment or Coinsurance listed above for most items does not apply to the items list under "Other items." Coverage and Copayment or Coinsurance for these other items is as follows:

Base drugs, supplies, and supplements		
Item	Your Copayment or Coinsurance	
	Plan Pharmacy	By Mail
Hematopoietic agents for dialysis	No charge for up to a 30-day supply	Not available

Base drugs, supplies, and supplements		
Elemental dietary enteral formula when used as a primary therapy for regional enteritis	No charge for up to a 30-day supply	Not available
Items listed below on the generic tier	\$5 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy
Items listed below on the brand-name tier	\$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy
Items listed below on the specialty tier	\$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy
<ul style="list-style-type: none"> • Drugs for the treatment of tuberculosis • Certain drugs for the treatment of life-threatening ventricular arrhythmia • Human growth hormone for long-term treatment of pediatric patients with growth failure from lack of adequate endogenous growth hormone secretion • Hematopoietic agents for the treatment of anemia in chronic renal insufficiency • Immunosuppressants and ganciclovir and ganciclovir prodrugs for the treatment of cytomegalovirus when prescribed in connection with a transplant • Phosphate binders for dialysis patients for the treatment of hyperphosphatemia in end stage renal disease 		

Anticancer Drugs and Certain Critical Adjuncts Following a Diagnosis of Cancer		
Oral anticancer drugs on the specialty tier	\$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy
Non-oral anticancer drugs on the generic tier	\$5 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy
Non-oral anticancer drugs on the brand-name tier	\$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy
Non-oral anticancer drugs on the specialty tier	\$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy

Home infusion drugs		
Item	Your Copayment or Coinsurance	
	Plan Pharmacy	By Mail
Home infusion drugs	No charge for up to a 30-day supply	Not available
Supplies necessary for administration of home infusion drugs	No charge	No charge
Home infusion drugs are self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion, such as an intravenous or intraspinal-infusion.		

Anticancer Drugs and Certain Critical Adjuncts Following a Diagnosis of Cancer		
Item	Your Copayment or Coinsurance	
	Plan Pharmacy	By Mail
Oral anticancer drugs on the generic tier	\$5 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy
Oral anticancer drugs on the brand-name tier	\$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy

Diabetes supplies and amino acid–modified products		
Item	Your Copayment or Coinsurance	
	Plan Pharmacy	By Mail
Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)	No charge for up to a 30-day supply	Not available
Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing	No charge for up to a 100-day supply	

Diabetes supplies and amino acid–modified products		
Insulin-administration devices: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear)	\$5 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy
Note: Drugs related to the treatment of diabetes (for example, insulin) are not covered under this "Diabetes supplies and amino-acid modified products" section		

Contraceptive drugs and devices		
Item	Your Copayment or Coinsurance	
	Plan Pharmacy	By Mail
The following contraceptive items for women on the generic tier when prescribed by a Plan Provider: Rings Patches Female condoms Oral contraceptives Spermicide Sponges	No charge for up to a 100-day supply	No charge for up to a 100-day supply Rings and items that do not require a prescription by law are not available for mail order
The following contraceptive items on the brand-name tier for women when prescribed by a Plan Provider: Rings Patches Female condoms Oral contraceptives Spermicide Sponges	No charge for up to a 100-day supply	No charge for up to a 100-day supply Rings and items that do not require a prescription by law are not available for mail order
Emergency contraception	No charge	Not available
Diaphragms and cervical caps	No charge	

Certain preventive items		
Item	Your Copayment or Coinsurance	
	Plan Pharmacy	By Mail
Items on our Preventive Services under Health Reform list posted on kp.org/prevention when prescribed by a Plan Provider	No charge for up to a 100-day supply	Not available

Infertility and sexual dysfunction drugs		
Item	Your Copayment or Coinsurance	
	Plan Pharmacy	By Mail
Drugs on the generic tier prescribed to treat infertility	50% Coinsurance for up to a 100-day supply	50% Coinsurance for up to a 100-day supply
Drugs on the brand-name and specialty tiers prescribed to treat infertility	50% Coinsurance for up to a 100-day supply	50% Coinsurance for up to a 100-day supply
Drugs on the generic tier prescribed in connection with a GIFT, ZIFT, or IVF cycle	Not covered	Not covered
Drugs on the brand-name and specialty tiers prescribed in connection with a GIFT, ZIFT, or IVF cycle	Not covered	Not covered
Drugs on the generic tier prescribed for sexual dysfunction disorders	50% Coinsurance (not to exceed \$50) for up to a 100-day supply	50% Coinsurance (not to exceed \$50) for up to a 100-day supply
Drugs on the brand-name and specialty tiers prescribed for sexual dysfunction disorders	50% Coinsurance (not to exceed \$100) for up to a 100-day supply	50% Coinsurance (not to exceed \$100) for up to a 100-day supply

Coverage for Services related to "Outpatient Prescription Drugs, Supplies, and Supplements" described in other sections

- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "Durable Medical Equipment for Home Use")
- 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")
- Durable medical equipment used to administer drugs (refer to "Durable Medical Equipment for Home Use")
- Outpatient administered drugs (refer to "Outpatient Care")

Outpatient prescription drugs, supplies, and supplements exclusion(s)

- 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

Preventive Services

We cover a variety of Preventive Services, including but not limited to the following:

- Services recommended by the United States Preventive Services Task Force with rating of "A" or "B." The complete list of these services can be found at uspreventiveservicestaskforce.org
- Immunizations listed on the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians
- Preventive services for women recommended by the Health Resources and Services Administration and incorporated into the Affordable Care Act. The complete list of these services can be found at hrsa.gov/womensguidelines

The list of Preventive Services recommended by the above organizations is subject to change. These Preventive Services are subject to all coverage requirements described in this "Benefits, Copayments, and Coinsurance" section and all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. You may obtain a list of Preventive Services we cover on our website at kp.org/prevention. If you have questions about Preventive Services, please call our Member Service Contact Center.

Note: If you receive any other covered Services that are not Preventive Services during or subsequent to a visit that includes Preventive Services on the list, you will pay the applicable Copayment or Coinsurance for those other Services.

You pay the following for covered Preventive Services:

- Preventive Services received during an office visit:
 - ♦ routine physical exams, including well-woman exams: **no charge**
 - ♦ well child preventive exams for Members through age 23 months: **no charge**
 - ♦ after confirmation of pregnancy, the normal series of regularly scheduled preventive prenatal care exams: **no charge**
 - ♦ immunizations (including the vaccine) administered to you in a Plan Medical Office: **no charge**
 - ♦ screening and counseling Services when provided during a routine physical exam such as obesity counseling, routine vision and hearing screenings, alcohol and substance abuse screenings, health education, depression screening, and developmental screenings to diagnose and assess potential developmental delays: **no charge**
- Outpatient procedures that are Preventive Services:
 - ♦ sterilization procedures for women: refer to "Family Planning Services" in this "Benefits, Copayments, and Coinsurance" section for coverage, Copayment and Coinsurance information
 - ♦ screening colonoscopies: **no charge**
 - ♦ screening flexible sigmoidoscopies: **no charge**
- Outpatient imaging and laboratory Services that are Preventive Services
 - ♦ routine imaging screenings such as mammograms: **no charge**
 - ♦ bone density CT scans: **no charge**
 - ♦ bone density DEXA scans: **no charge**
 - ♦ routine laboratory tests and screenings such as cancer screening tests, sexually transmitted disease (STD) tests, cholesterol screening tests, and glucose tolerance tests: **no charge**
 - ♦ other laboratory screening tests, such as fecal occult blood tests and hepatitis B screening tests: **no charge**
- Outpatient prescription drugs, supplies and supplements that are Preventive Services:
 - ♦ implanted contraceptive drugs and devices for women: refer to "Family Planning Services" in this "Benefits, Copayments, and Coinsurance" section

for coverage, Copayment and Coinsurance for provider-administered contraceptive drugs and implanted contraceptive devices

- ◆ other contraceptive drugs and devices for women: refer to "Outpatient drugs, supplies, and supplements" in this "Benefits, Copayments, and Coinsurance" section for coverage, Copayment and Coinsurance information for all other contraceptive drugs and devices
- Other Preventive Services:
 - ◆ breast pumps and breastfeeding supplies: refer to "Breastfeeding supplies" under "Durable Medical Equipment for Home Use" in this "Benefits, Copayments, and Coinsurance" section for coverage, Copayment and Coinsurance information

Coverage related to "Preventive Services" described in other sections

- Breast pumps and breastfeeding supplies (refer to "Breastfeeding supplies" under "Durable Medical Equipment for Home Use")
- Health education programs (refer to "Health Education")
- Outpatient drugs, supplies, and supplements that are Preventive Services (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Women's family planning counseling, consultations, and sterilization Services (refer to "Family Planning Services")

Prosthetic and Orthotic Devices

Inside California, we cover the prosthetic and orthotic devices specified 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, and Services to determine whether you need a prosthetic or orthotic device. If we cover a replacement device, then you pay the Copayment or Coinsurance that you would pay for obtaining that device.

Prosthetic and orthotic devices that are essential health benefits

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, Copayments, and Coinsurance" section. We cover these devices at **no charge**.

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

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- After a Medically Necessary mastectomy:
 - ◆ prostheses, including custom-made prostheses when Medically Necessary
 - ◆ up to three brassieres required to hold a prosthesis in any 12-month period
- 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

Prosthetic and orthotic devices that are not essential health benefits

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

- Prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity
- Rigid and semi-rigid orthotic devices required to support or correct a defective body part
- Covered special footwear when custom made for foot disfigurement due to disease, injury, or developmental disability

Coverage for Services related to "Prosthetic and Orthotic Devices" described in other sections

- "Eyeglasses and "contact lenses (refer to "Vision Services for Adult Members" and "Vision Services for Pediatric Members")
- Hearing aids other than internally implanted devices described in this section (refer to "Hearing Services")

Prosthetic and orthotic devices exclusion(s)

- Comfort, convenience, or luxury equipment or features
- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Nonrigid supplies, such as elastic stockings and wigs, except as otherwise described above in this "Prosthetic and Orthotic Devices" section
- Repair or replacement of device due to loss or misuse
- Shoes, shoe inserts, arch supports, or any other footwear, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications and foot disfigurement
- Orthotic devices not intended for maintaining normal activities of daily living (including devices intended to provide additional support for recreational or sports activities)

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:

- Primary Care Visits for evaluations and treatment and Non-Physician Specialist Visits for consultations, evaluations, and treatment: **a \$15 Copayment per visit**
- Physician Specialist Visits for consultations, evaluations, and treatment: **a \$15 Copayment per visit**

- Outpatient surgery and outpatient procedures when 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: **a \$15 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a \$15 Copayment per procedure**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Copayment or Coinsurance that would otherwise apply for the procedure** in this "Benefits, Copayments, and Coinsurance" 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")
- Hospital inpatient care (including room and board, drugs, imaging, laboratory, special procedures, and Plan Physician Services): **no charge**

Coverage for Services related to "Reconstructive Surgery" described in other sections

- 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 exclusion(s)

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance

Rehabilitative and Habilitative Services

We cover the Services described in this "Rehabilitative and Habilitative Services" section if all of the following requirements are met:

- The Services are to address a health condition

- The Services are to help you partially or fully acquire or improve skills and functioning needed to perform activities of daily living, to the maximum extent practical

We cover the following Services at the Copayment or Coinsurance indicated:

- Individual outpatient physical, occupational, and speech therapy related to pervasive developmental disorder or autism: **a \$15 Copayment per visit**
- Group outpatient physical, occupational, and speech therapy related to pervasive developmental disorder or autism: **a \$7 Copayment per visit**
- All other individual outpatient physical, occupational, and speech therapy: **a \$15 Copayment per visit**
- All other group outpatient physical, occupational, and speech therapy: **a \$7 Copayment per visit**
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program: **a \$15 Copayment per day**
- Physical, occupational, and speech therapy provided in a Skilled Nursing Facility (subject to the day limits described in the "Skilled Nursing Facility Care" section): **You pay the Copayment or Coinsurance for Skilled Nursing Facility care as described under "Skilled Nursing Facility Care" in this "Benefits, Copayments, and Coinsurance" section**
- Physical, occupational, and speech therapy provided in an inpatient hospital (including treatment in an organized multidisciplinary rehabilitation program): **You pay the Copayment or Coinsurance for inpatient care as described under "Hospital Inpatient Care" in this "Benefits, Copayments, and Coinsurance" section**

Coverage for Services related to "Rehabilitative and Habilitative Services" described in other sections

- Behavioral health treatment for pervasive developmental disorder or autism (refer to "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism")
- Home health care (refer to "Home Health Care")
- Durable medical equipment (refer to "Durable Medical Equipment for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Rehabilitative and Habilitative Services exclusion(s)

- Items and services that are not health care items and services (for example, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including vocational training)

Services in Connection with a Clinical Trial

We cover Services you receive in connection with a clinical trial if all of the following requirements are met:

- We would have covered the Services if they were not related to a clinical trial
- You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
 - ◆ A Plan Provider makes this determination
 - ◆ You provide us with medical and scientific information establishing this determination
- If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live
- The clinical trial is an Approved Clinical Trial

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having an investigational new drug application
- The study or investigation is approved or funded by at least one of the following:
 - ◆ the National Institutes of Health
 - ◆ the Centers for Disease Control and Prevention
 - ◆ the Agency for Health Care Research and Quality
 - ◆ the Centers for Medicare & Medicaid Services

- ◆ a cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs
- ◆ a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
- ◆ the Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved through a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review

For covered Services related to a clinical trial, you will pay the **Copayment or Coinsurance you would pay if the Services were not related to a clinical trial**. For example, see "Hospital Inpatient Care" in this "Benefits, Copayments, and Coinsurance" section for the Copayment or Coinsurance that applies for hospital inpatient care.

Services in connection with a clinical trial exclusion(s)

- The investigational Service
- Services that are provided solely to satisfy data collection and analysis needs and are not used in your clinical management

Skilled Nursing Facility Care

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

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
- Behavioral health treatment for pervasive developmental disorder or autism
- Respiratory therapy

Coverage for Services related to "Skilled Nursing Facility Care" described in other sections

- Outpatient imaging, laboratory, and special procedures (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Physical, occupational, and speech therapy (refer to "Rehabilitative and Habilitative Services")

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. Please call our Member Service Contact Center for questions about donor Services

For covered transplant Services that you receive, you will pay the **Copayment or Coinsurance you would pay if the Services were not related to a transplant**. For example, see "Hospital Inpatient Care" in this "Benefits, Copayments, and Coinsurance" section for the Copayment or Coinsurance that applies for hospital inpatient care.

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**.

Coverage for Services related to "Transplant Services" described in other sections

- 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 for Adult Members

We cover the following for Adult Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses: **no charge**
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **a \$15 Copayment per visit**
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **a \$15 Copayment per visit**

Optical Services

We cover the Services described in this "Optical Services" section at Plan Medical Offices or Plan Optical Sales Offices.

Eyeglasses and contact lenses following cataract surgery. We cover at **no charge** one pair of eyeglasses or contact lenses (including fitting or dispensing) following each cataract surgery that includes insertion of an intraocular lens at Plan Medical Offices or Plan Optical Sales Offices when prescribed by a physician or optometrist. When multiple cataract surgeries are needed, and you do not obtain eyeglasses or contact lenses between procedures, we will only cover one pair of eyeglasses or contact lenses after any surgery. If the eyewear you purchase costs more than what Medicare covers for someone who has Original Medicare (also known as "Fee-for-Service Medicare"), you pay the difference. We will not cover the eyewear described in this paragraph if we provided an allowance toward, or otherwise covered, eyeglasses or contact lenses under this or any other benefit for eyeglasses or contact lenses following cataract surgery.

Special contact lenses. We cover the following at the Copayment or Coinsurance indicated:

- Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris) when prescribed by a Plan Physician or Plan Optometrist at **no charge**. We will not cover an aniridia contact lens if we provided an allowance toward (or otherwise covered) more than one aniridia contact lens for that eye within the previous 12 months (including when we provided an allowance toward, or otherwise covered, one or more aniridia contact lenses under any other evidence of coverage offered by your Group)

Low vision devices

Low vision devices (including fitting and dispensing) are not covered.

Coverage for Services related to "Vision Services for Adult Members" described in other sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than Services covered under this "Vision Services for Adult Members" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits, Copayments, and Coinsurance" section)

Vision Services for Adult Members exclusion(s)

- Contact lenses, including fitting and dispensing (except for special contact lenses and contact lenses

following cataract surgery, as described under this "Vision Services for Adult Members" section)

- Eyeglass lenses and frames (except for eyewear following cataract surgery, as described under this "Vision Services for Adult Members" section)
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Industrial frames
- Low vision devices

Vision Services for Pediatric Members

We cover the following for Pediatric Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses: **no charge**
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **a \$15 Copayment per visit**
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **a \$15 Copayment per visit**

Optical Services

We cover the Services described in this "Optical Services" section at Plan Medical Offices or Plan Optical Sales Offices.

Eyeglasses and contact lenses following cataract surgery. We cover at **no charge** one pair of eyeglasses or contact lenses (including fitting or dispensing) following each cataract surgery that includes insertion of an intraocular lens at Plan Medical Offices or Plan Optical Sales Offices when prescribed by a physician or optometrist. When multiple cataract surgeries are needed, and you do not obtain eyeglasses or contact lenses between procedures, we will only cover one pair of eyeglasses or contact lenses after any surgery. If the eyewear you purchase costs more than what Medicare covers for someone who has Original Medicare (also known as "Fee-for-Service Medicare"), you pay the difference. We will not cover the eyewear described in this paragraph if we provided an allowance toward, or otherwise covered, eyeglasses or contact lenses under this or any other benefit for eyeglasses or contact lenses following cataract surgery.

Special contact lenses. We cover the following at the Copayment or Coinsurance indicated:

- Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris) when prescribed

by a Plan Physician or Plan Optometrist at **no charge**. We will not cover an aniridia contact lens if we provided an allowance toward (or otherwise covered) more than one aniridia contact lens for that eye within the previous 12 months (including when we provided an allowance toward, or otherwise covered, one or more aniridia contact lenses under any other evidence of coverage offered by your Group)

- For aphakia (absence of the crystalline lens of the eye), we cover up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period for Members through age 9 at **no charge** when prescribed by a Plan Physician or Plan Optometrist. We will not cover an aphakic contact lens if we provided an allowance toward (or otherwise covered) more than six aphakic contact lenses for that eye during the same 12-month period (including when we provided an allowance toward, or otherwise covered, one or more aphakic contact lenses under any other evidence of coverage offered by your Group)

Low vision devices

Low vision devices (including fitting and dispensing) are not covered.

Coverage for Services related to "Vision Services for Pediatric Members" described in other sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than Services covered under this "Vision Services for Pediatric Members" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits, Copayments, and Coinsurance" section)

Vision Services for Pediatric Members exclusion(s)

- Contact lenses, including fitting and dispensing (except for special contact lenses as described under this "Vision Services for Pediatric Members" section)
- Eyeglasses lenses and frames
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Industrial frames
- 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 *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 this *Evidence of Coverage*.

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, unless you have coverage for supplemental chiropractic Services as described in an amendment to this *Evidence of Coverage*.

Cosmetic Services

Services that are intended primarily to change or maintain your appearance (including Cosmetic Surgery, which is defined as surgery that is performed to alter or reshape normal structures of the body in order to improve appearance), except that this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "Benefits, Copayments, and Coinsurance" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "Benefits, Copayments, and Coinsurance" 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, Copayments, and Coinsurance" section or to pediatric dental Services described in a Pediatric Dental Services Amendment to this *Evidence of Coverage*.

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, Copayments, and Coinsurance" 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 in Connection with a Clinical Trial" in the "Benefits, Copayments, and Coinsurance" 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.

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Durable Medical Equipment for Home Use," "Home Health Care," and "Hospice Care" in the "Benefits, Copayments, and Coinsurance" 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 for the purpose of increasing 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, except that this exclusion for "teaching play" does not apply to Services that are part of a behavioral health therapy treatment plan and covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the "Benefits, Copayments, and Coinsurance" section
- 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, except that this exclusion for aquatic therapy and other water therapy does not apply to therapy Services that are

part of a physical therapy treatment plan and covered under "Home Health Care," "Hospice Services," or "Rehabilitative and Habilitative Services" in the "Benefits, Copayments, and Coinsurance" section

Items and services to correct refractive defects of the eye

Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism.

Massage therapy

Massage therapy, except that this exclusion does not apply to therapy Services that are part of a physical therapy treatment plan and covered under "Home Health Care," "Hospice Services," or "Rehabilitative and Habilitative Services" in the "Benefits, Copayments, and Coinsurance" section.

Oral nutrition

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

This exclusion does not apply to any of the following:

- Amino acid–modified products and elemental dietary enteral formula covered under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits, Copayments, and Coinsurance" section
- Enteral formula covered under "Prosthetic and Orthotic Devices" in the "Benefits, Copayments, and Coinsurance" 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, or residential treatment program Services covered in the "Chemical Dependency Services" and "Mental Health Services" sections.

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 in Connection with a Clinical Trial" in the "Benefits, Copayments, and Coinsurance" 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.

This exclusion does not apply to Services covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the "Benefits, Copayments, and Coinsurance" section.

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 (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. 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 obligations to reimburse us for any Services we cover and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.

Travel and lodging expenses

Travel and lodging expenses, except for the following:

- 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. Please call our Member Service Contact Center for questions about travel and lodging
- Reimbursement for travel and lodging expenses provided under "Bariatric Surgery" in the "Benefits, Copayments, and Coinsurance" 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 *Evidence of Coverage*, such as a 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 dispute. 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 this *Evidence of Coverage*.

Coordination of Benefits

The Services covered under this *Evidence of Coverage* are subject to coordination of benefits rules.

Coverage other than Medicare coverage

If you have medical or dental coverage under another plan that is subject to coordination of benefits, we will coordinate benefits with the other coverage under the coordination of benefits rules of the California

Department of Managed Health Care. Those rules are incorporated into this *Evidence of Coverage*.

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

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

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

Medicare coverage

If you have Medicare coverage, we will coordinate benefits with the 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 Contact Center to find out which Medicare rules apply to your situation, and how payment will be handled.

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 your Copayment or Coinsurance 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:

For Northern California Members:

Trover Solutions, Inc.
Kaiser Permanente - Northern California Region
Subrogation Mailbox
9390 Bunsen Parkway
Louisville, KY 40220

For Southern California Members:

The Rawlings Group
Subrogation Mailbox
P.O. Box 2000
LaGrange, KY 40031

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 and you or any other payee are entitled to receive payments or other compensation under the Surrogacy Arrangement, you must pay us Charges for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed the maximum amount allowed under California Civil Code Section 3040. A "Surrogacy Arrangement" is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Note: This "Surrogacy arrangements" section does not affect your obligation to pay your Copayment or Coinsurance for these Services, but we will credit any such payments toward the amount you must pay us under this paragraph. After you surrender a baby to the legal parents, you are not

obligated to pay Charges for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or any other 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 and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds 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 all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receive
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

For Northern California Members:

Trover Solutions, Inc.
Kaiser Permanente - Northern California Region
Surrogacy Mailbox
9390 Bunsen Parkway
Louisville, KY 40220

For Southern California Members:

The Rawlings Group
Surrogacy Mailbox
P.O. Box 2000
LaGrange, KY 40031

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 "Surrogacy arrangements" section 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.

If you have questions about your obligations under this provision, please contact our Member Service Contact Center.

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

Post-Service Claims and Appeals

This "Post-Service Claims and Appeals" section explains how to file a claim for payment or reimbursement for

Services that you have already received. Please use the procedures in this section in the following situations:

- You have received Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services from a Non-Plan Provider and you want us to pay for the Services
- You have received Services from a Non-Plan Provider that we did not authorize (other than Emergency Services, Out-of-Area Urgent Care, Post-Stabilization Care, or emergency Ambulance Services) and you want us to pay for the Services
- You want to appeal a denial of an initial claim for payment

Please follow the procedures under "Grievances" in the "Dispute Resolution" section in the following situations:

- You want us to cover Services that you have not yet received
- You want us to continue to cover an ongoing course of covered treatment
- You want to appeal a written denial of a request for Services that require prior authorization (as described under "Medical Group authorization procedure for certain referrals")

Who May File

The following people may file claims:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a claim for you by appointing him or her in writing as your authorized representative
- A parent may file for his or her child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the claim
- A court-appointed guardian may file for his or her ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the claim
- A court-appointed conservator may file for his or her conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for his or her principal

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available

from the Member Services Department at a Plan Facility, on our website at **kp.org**, or by calling our Member Service Contact Center. Your written authorization must accompany the claim. You must pay the cost of anyone you hire to represent or help you.

Supporting Documents

You can request payment or reimbursement orally or in writing. Your request for payment or reimbursement, and any related documents that you give us, constitute your claim.

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

To file a claim in writing for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services, please use our claim form. You can obtain a claim form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers
- By calling our Member Service Contact Center at 1-800-464-4000 or 1-800-390-3510 (TTY users call 711)

Claims forms for all other Services

To file a claim in writing for all other Services, you may use our Complaint or Benefit Claim/Request form. You can obtain this form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers
- By calling our Member Service Contact Center at 1-800-464-4000 (TTY users call 711)

Other supporting information

When you file a claim, please include any information that clarifies or supports your position. For example, if you have paid for Services, please include any bills and receipts that support your claim. To request that we pay a Non-Plan Provider for Services, include any bills from the Non-Plan Provider. If the Non-Plan Provider states that they will file the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. When appropriate, we will request medical records from Plan Providers on your behalf. If you tell us that 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 relevant

medical records. We will ask you to provide us a written authorization so that we can request your records.

If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should follow the steps in the written notice sent to you about your claim.

Initial Claims

To request that we pay a provider (or reimburse you) for Services that you have already received, you must file a claim. If you have any questions about the claims process, please call our Member Service Contact Center.

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

If you have received Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services from a Non-Plan Provider, then as soon as possible after you received the Services, you must file your claim by mailing a completed claim form and supporting information to the following address:

For Northern California Members:

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

For Southern California Members:

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

Please call our Member Service Contact Center if you need help filing your claim.

Submitting a claim for all other Services

If you have received Services 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), then as soon as possible after you receive the Services, you must file your claim in one of the following ways:

- By delivering your claim to a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By mailing your claim to a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By calling our Member Service Contact Center at 1-800-464-4000 (TTY users call 711)
- By visiting our website at **kp.org**

Please call our Member Service Contact Center if you need help filing your claim.

After we receive your claim

We will send you an acknowledgment letter within five days after we receive your claim.

After we review your claim, we will respond as follows:

- If we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 30 days after we receive your claim
- If we need more information, we will ask you for the information before the end of the initial 30-day decision period. We will send our written decision no later than 15 days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in our letter, we will make our decision based on the information we have within 15 days after the end of that timeframe

If we pay any part of your claim, we will subtract applicable Copayment or Coinsurance from any payment we make to you or the Non-Plan Provider. You are not responsible for any amounts beyond your Copayments or Coinsurance for covered Emergency Services. If we deny your claim (if we do not agree to pay for all the Services you requested other than the applicable Copayments or Coinsurance), our letter will explain why we denied your claim and how you can appeal.

If you later receive any bills from the Non-Plan Provider for covered Services (other than bills for your Copayments or Coinsurance), please call our Member Service Contact Center for assistance.

Appeals

Claims for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency

ambulance Services from a Non-Plan Provider. If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By mailing your appeal 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 Contact Center at 1-800-464-4000 (TTY users call 711)
- By visiting our website at **kp.org**

Claims for Services 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). If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By mailing your appeal to the Member Services Department at a Plan Facility (please refer to *Your Guidebook* for addresses)
- In person from any Member Services office at a Plan Facility and from Plan Providers
- By calling our Member Service Contact Center at 1-800-464-4000 (TTY users call 711)
- By visiting our website at **kp.org**

When you file an appeal, please include any information that clarifies or supports your position. If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should contact our Member Service Contact Center.

Additional information regarding a claim for Services 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). If we initially denied your request, you must file your appeal within 180 days after the date you received our denial letter. You may send us information including comments, documents, and medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal. Please send all additional

information to the address or fax mentioned in your denial letter.

Also, you may give testimony in writing or by telephone. Please send your written testimony to the address mentioned in our acknowledgment letter, sent to you within five days after we receive your appeal. To arrange to give testimony by telephone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will review it without regard to whether this information was filed or considered in our initial decision regarding your request for Services. You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our final decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

We will send you a resolution letter within 30 days after we receive your appeal. If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

External Review

You must exhaust our internal claims and appeals procedures before you may request external review unless we have failed to comply with the claims and appeals procedures described in this "Post-Service Claims and Appeals" section. For information about external review process, see "Independent Medical Review (IMR)" in the "Dispute Resolution" section.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims

and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (1-866-444-3272)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Dispute Resolution

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 Contact Center.

Grievances

This "Grievances" section describes our grievance procedure. A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. If you want to make a claim for payment or reimbursement for Services that you have already received from a Non-Plan Provider, please follow the procedure in the "Post-Service Claims and Appeals" section.

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 and you want us to cover the Services
- You received a written denial for a second opinion
- Your treating 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 want us to continue to cover an ongoing course of covered treatment

- 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
- We terminated your membership and you disagree with that termination

Who may file

The following people may file a grievance:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a grievance for you by appointing him or her in writing as your authorized representative
- A parent may file for his or her child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the grievance
- A court-appointed guardian may file for his or her ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the grievance
- A court-appointed conservator may file for his or her conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for his or her principal
- Your physician may act as your authorized representative with your verbal consent to request an urgent grievance as described under "Urgent procedure" in this "Grievances" section

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services Department at a Plan Facility, on our website at **kp.org**, or by calling our Member Service Contact Center. Your written authorization must accompany the grievance. You must pay the cost of anyone you hire to represent or help you.

How to file

You can file a grievance orally or in writing. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with the Services you received.

To file a grievance in writing, please use our Complaint or Benefit Claim/Request form. You can obtain the form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers
- By calling our Member Service Contact Center at 1-800-464-4000 (TTY users call 711)

You must file your grievance within 180 days following the incident or action that is subject to your dissatisfaction. You may send us information including comments, documents, and medical records that you believe support your grievance.

Standard procedure. You must file your grievance in one of the following ways:

- By completing a Complaint or Benefit Claim/Request form at a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By mailing your grievance to a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By calling our Member Service Contact Center at 1-800-464-4000 (TTY users call 711)
- By completing the grievance form on our website at **kp.org**

Please call our Member Service Contact Center if you need help filing a grievance.

If your grievance involves a request to obtain a non-formulary prescription drug, we will notify you of our decision within 72 hours. If we do not decide in your favor, our letter will explain why and describe your further appeal rights, including how you may request an external review of your request

For all other grievances we will send you an acknowledgment letter within five days after we receive your grievance. We will send you a resolution letter within 30 days after we receive your grievance. If you are requesting Services, and we do not decide in your favor, our letter will explain why and describe your further appeal rights.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should contact our Member Service Contact Center.

Urgent procedure. If you want us to consider your grievance on an urgent basis, please tell us that when you file your grievance.

You must file your urgent grievance in one of the following ways:

- By calling our Expedited Review Unit toll free at 1-888-987-7247 (TTY users call 711)
- By mailing a written request to:
Kaiser Foundation Health Plan, Inc.
Expedited Review Unit
P.O. Box 23170
Oakland, CA 94623-0170
- By faxing a written request to our Expedited Review Unit toll free at 1-888-987-2252
- By visiting a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By completing the grievance form on our website at **kp.org**

We will decide whether your grievance is urgent or non-urgent unless your attending health care provider tells us your grievance is urgent. If we determine that your grievance is not urgent, we will use the procedure described under "Standard procedure" in this "Grievances" section. Generally, a grievance is urgent only if one of the following is true:

- Using the standard procedure could seriously jeopardize your life, health, or ability to regain maximum function
- Using the standard procedure would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment
- A physician with knowledge of your medical condition determines that your grievance is urgent

If your grievance involves a request to obtain a non-formulary prescription drug and we respond to your request on an urgent basis, we will notify you of our decision within 24 hours of your request. If we do not decide in your favor, our letter will explain why and describe your further appeal rights, including how you may request an external review of your request.

For all other grievances that we respond to on an urgent basis, we will give you oral notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your grievance. We will

send you a written confirmation of our decision within 3 days after we received your grievance.

If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

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 at any time at 1-888-HMO-2219 (TDD 1-877-688-9891) without first filing a grievance with us.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should contact our Member Service Contact Center.

Additional information regarding pre-service requests for Medically Necessary Services. You may give testimony in writing or by telephone. Please send your written testimony to the address mentioned in our acknowledgment letter. To arrange to give testimony by telephone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your grievance file and we will consider it in our decision regarding your pre-service request for Medically Necessary Services.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your grievance is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your grievance file.

Additional information regarding appeals of written denials for Services that require prior authorization. You must file your appeal within 180 days after the date you received our denial letter.

You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your appeal.

Also, you may give testimony in writing or by telephone. Please send your written testimony to the address mentioned in our acknowledgment letter. To arrange to give testimony by telephone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will consider it in our decision regarding your appeal.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your appeal is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

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 711) 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)

Except as described in this "Independent Medical Review (IMR)" section, you must exhaust our internal grievance procedure before you may request independent medical review unless we have failed to comply with the grievance procedure described under "Grievances" in this "Dispute Resolution" section. 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 urgent grievances). The Department of Managed Health Care (DMHC) may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function. If we have denied your grievance, you must submit your request for an IMR within 6 months of the date of our written denial. However, the DMHC may accept your request after 6 months if they determine that circumstances prevented timely submission

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 three days after we received your request. 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.

Appeal Procedure Following Disposition of Health Plan's Grievance Process

If you do not achieve resolution of your complaint through the grievance process described under "Grievances", "Department of Managed Health Care Complaints" or "Independent Medical Review (IMR)," you have additional dispute resolution options, depending on the nature of the complaint.

Eligibility issues

Issues of eligibility must be referred directly to CalPERS at:

CalPERS
Member Account Management Division
Attn: Enrollment Administration
P.O. Box 942714
Sacramento, CA 94229-2714

Fax: (916)795-1277, or telephone the CalPERS Customer Service and Outreach Division toll free at **888 CalPERS** (or **888-225-7377**).

Coverage issues

If you have a coverage issue and are dissatisfied with the outcome of our grievance process or if you have been in the process for 30 days or more, you may request review by the Department of Managed Health Care (as described under "Department of Managed Health Care Complaints"), or you may submit the matter to binding arbitration (or Small Claims Court if applicable). A coverage issue concerns the denial of Services substantially based on a finding that a Service is excluded as a covered benefit under this *Evidence of Coverage*. Coverage issues do not include a Plan Provider's decision about a disputed Service. However, you must choose between the Department of Managed Health Care and binding arbitration. If you choose to submit the issue to binding arbitration (or Small Claims Court if applicable), you may not request a CalPERS Administrative Review of your dispute.

Independent Medical Review (IMR)

If you are dissatisfied with the outcome of the independent medical review process described under the "Independent Medical Review (IMR)" section, you may

request an Administrative Review through CalPERS, or you may submit the matter to binding arbitration (or Small Claims Court if applicable). If you choose to submit the issue to binding arbitration (or Small Claims Court if applicable), you may not request a CalPERS Administrative Review of your dispute.

CalPERS Administrative Review process

If you remain dissatisfied with the DMHC's determination or the IMR's determination, you may request an Administrative Review. You must exhaust our internal grievance process, the DMHC's process and the IMR process, when applicable, prior to submitting a request for CalPERS Administrative Review.

The request for an Administrative Review must be submitted in writing to CalPERS within thirty (30) days from the date of the DMHC's determination or, the IMR determination letter, in cases involving a Disputed Health Care Service, or Experimental or Investigational determination.

The request must be mailed to:
CalPERS Health Plan Administration Division
Health Appeals Coordinator
P.O. Box 1953
Sacramento, CA 95812-1953

If you are planning to submit information we may have regarding your dispute with your request for Administrative Review, please note that we may require you to sign an authorization form to release this information. In addition, if CalPERS determines that additional information is needed after we submit the information we have regarding your dispute, CalPERS may ask you sign an Authorization to Release Health Information (ARHI) form.

If you have additional medical records from Providers or scientific studies that you believe are relevant to CalPERS review, those records should be included with the written request. You should send copies of documents, not originals, as CalPERS will retain the documents for its files. You are responsible for the cost of copying and mailing medical records required for the Administrative Review. Providing supporting information to CalPERS is voluntary. However, failure to provide such information may delay or preclude CalPERS in providing a final Administrative Review determination.

CalPERS cannot review claims of medical malpractice, i.e. quality of care, or quality of service disputes.

CalPERS will attempt to provide a written determination within 60 days from the date all pertinent information is received by CalPERS. For claims involving urgent care, CalPERS will make a decision as soon as possible, taking into account the medical exigencies, but no later than three (3) business days from the date all pertinent information is received by CalPERS.

Note: In urgent situations, if you request an IMR at the same time you submit a request for CalPERS Administrative Review, but before a determination has been made by the IMR, CalPERS will not begin its review or issue a determination until the IMR determination is issued.

CalPERS Administrative Hearing process

You must complete the CalPERS Administrative Review process prior to being offered the opportunity for an Administrative Hearing. Only claims involving covered benefits are eligible for an Administrative Hearing.

During the hearing, evidence and testimony will be presented to an Administrative Law Judge. As an alternative to this hearing, you may have recourse through binding arbitration (or Small Claims Court if applicable). However, you must choose between the Administrative Hearing and binding arbitration (or Small Claims Court if applicable). You may not take the same issue through both procedures. You may withdraw your request from CalPERS at any time, and proceed to binding arbitration (or Small Claims Court if applicable).

You must request an Administrative Hearing in writing within 30 days of the date of the Administrative Review determination. Upon satisfactorily showing good cause, CalPERS may grant additional time to file a request for an Administrative Hearing, not to exceed 30 days.

The request for an Administrative Hearing must set forth the facts and the law upon which the request is based. The request should include any additional arguments and evidence favorable to a member's case not previously submitted for Administrative Review, DMHC and IMR.

If CalPERS accepts the request for an Administrative Hearing, it shall be conducted in accordance with the Administrative Procedure Act (Government Code section 11500 et seq.). An Administrative Hearing is a formal legal proceeding held before an Administrative Law Judge (ALJ); you may, but are not required to, be represented by an attorney. After taking testimony and receiving evidence, the ALJ will issue a Proposed Decision. The CalPERS Board of Administration (Board) will vote regarding whether to adopt the Proposed Decision as its own decision at an open (public) meeting. The Board's final decision will be provided in writing to you within two weeks of the Board's open meeting.

Appeal Beyond Administrative Review and Administrative Hearing

If you are dissatisfied with the Board's decision, you may petition the Board for reconsideration of its decision, or may appeal to the Superior Court.

You may not begin civil legal remedies until after exhausting these administrative procedures.

Summary of Process and Rights of Members under the Administrative Procedure Act.

- **Right to records, generally.** You may, at your own expense, obtain copies of all non-medical and non-privileged medical records from us and/or CalPERS, as applicable
- **Records subject to attorney-client privilege.** Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances
- **Attorney Representation.** At any stage of the appeal proceedings, you may be represented by an attorney. If you choose to be represented by an attorney, you must do so at your own expense. Neither CalPERS nor Health Plan will provide an attorney or reimburse you for the cost of an attorney even if you prevail on appeal
- **Right to experts and consultants.** At any stage of the proceedings, you may present information through the opinion of an expert, such as a physician. If you choose to retain an expert to assist in presentation of a claim, it must be at your own expense. Neither CalPERS nor Health Plan will reimburse you for the costs of experts, consultants or evaluations

Service of Legal Process

Legal process or service upon CalPERS must be served in person at:

CalPERS Legal Office
Lincoln Plaza North
400 "Q" Street
Sacramento, CA 95814

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our grievance procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (1-866-444-3272)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Binding Arbitration

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

Scope of arbitration

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

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

- Governing law does not prevent the use of binding arbitration to resolve the claim

Members enrolled under this *Evidence of Coverage* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeal procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

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 Southern California Permanente Medical Group or The 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.

Rules of Procedure

Arbitrations shall be conducted according to the *Rules for Kaiser Permanente Member Arbitrations Overseen*

by the Office of the Independent Administrator ("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 Contact Center.

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 in the Demand for Arbitration all claims against Respondents that are based on the same incident, transaction, or related circumstances.

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:

For Northern California Members:
Kaiser Foundation Health Plan, Inc.
Legal Department
1950 Franklin St., 17th Floor
Oakland, CA 94612

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

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

Filing fee

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

Any Claimant who claims extreme hardship may request that the 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 Contact Center.

Number of arbitrators

The number of arbitrators may affect the Claimants' responsibility for paying the neutral arbitrator's fees and expenses (see the Rules of Procedure).

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 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.

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 Respondent 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 non-economic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted 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. In accord with the rule that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration" section shall not be denied, stayed, or otherwise impeded because a dispute between a Member Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with a third party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. The guidelines that determine the termination of coverage from the CalPERS Health Program are governed in accord with the Public Employees' Medical & Hospital Care Act (PEMHCA). For an explanation of specific eligibility criteria and termination requirements, please consult your Health Benefits Officer (or, if you are retired, the CalPERS Member Account Management Division). Your

CalPERS Health Program Guide also includes eligibility and termination information and can be ordered through the CalPERS website or by calling CalPERS.

Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2018, your last minute of coverage was at 11:59 p.m. on December 31, 2017). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates.

Health Plan and Plan Providers have no further liability or responsibility under this *Evidence of Coverage* after your membership terminates, except as provided under "Payments after Termination" in this "Termination of Membership" section, or if your coverage terminates for one of the reasons listed below and you are receiving covered Services as an acute care hospital inpatient on the termination date, we will continue to cover your hospital Services until you are discharged. We will cover only 91 days of continuous hospitalization after the termination date if one of the following is true:

- Your membership terminated due to a change from one CalPERS-sponsored plan to another (if you are still hospitalized on the 92nd day, your coverage under the newly chosen CalPERS-sponsored plan will take effect)
- Your membership terminated for a reason other than termination of your Group's *Agreement* with us or voluntary termination by the Subscriber

Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements described under "Eligibility" in the "Premiums, Eligibility, and Enrollment" section, CalPERS will notify you of the date that your membership will end. Your membership termination date is the first day you are not covered. For example, if your termination date is January 1, 2018, your last minute of coverage was at 11:59 p.m. on December 31, 2017.

Termination of Agreement

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

Termination for Cause

If you intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider, we will ask CalPERS to approve termination of your membership in accord with Section 22841 of the California Government Code. 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. For example, you have entered into a Surrogacy Arrangement and you fail to send us the information we require under "Surrogacy arrangements" under "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section
- Failing to notify us of changes in family status or Medicare coverage that may affect your eligibility or benefits

If CalPERS approves termination of your membership, CalPERS will send written notice to the Subscriber.

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 of a Product or all Products

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

Payments after Termination

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

- Refund any amounts we owe your Group for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in

accord with the "Emergency 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).

Continuation of Membership

If your membership under this *Evidence of Coverage* ends, you may be eligible to continue Health Plan membership without a break in coverage. You may be able to continue Group coverage under this *Evidence of Coverage* as described under "Continuation of Group Coverage." Also, you may be able to continue membership under an individual plan as described under "Continuation of Coverage under an Individual Plan." If at any time you become entitled to continuation of Group coverage, please examine your coverage options carefully before declining this coverage. Individual plan premiums and coverage will be different from the premiums and coverage under your Group plan.

Continuation of Group Coverage

COBRA

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

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Health Benefits Officer (or, if you are retired, the CalPERS Member Account Management Division) for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and Premiums may change, and where to send your Premium payments.

If you enroll in COBRA and exhaust the time limit for COBRA coverage, you may be able to continue Group coverage under state law as described under "Cal-COBRA" in this "Continuation of Group Coverage" section.

Cal-COBRA

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

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

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

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

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

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

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

Changes to Cal-COBRA coverage and Premiums.

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

Cal-COBRA open enrollment or termination of another health plan. If you previously elected Cal-COBRA coverage through another health plan available through your Group, you may be eligible to enroll in Kaiser Permanente during your Group's annual open enrollment period, or if your Group terminates its agreement with the health plan you are enrolled in. You will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA. Please ask your Group for information about health plans available to you either at open enrollment or if your Group terminates a health plan's agreement, please contact the CalPERS Member Account Management Division, Attn: Enrollment Administration, P.O. Box 942714, Sacramento, CA 94229-2714, fax number 916-795-1277, or telephone the CalPERS Customer Service and Outreach Division toll free at **888 CalPERS** (or **888-225-7377**).

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

payment by the due date on the bill to be enrolled in Cal-COBRA.

How you may terminate your Cal-COBRA coverage.

You may terminate your Cal-COBRA coverage 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 your Cal-COBRA coverage, including Premiums, for the period prior to your termination date.

Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 23127
San Diego, CA 92193-3127

Termination for nonpayment of Cal-COBRA

Premiums. If you do not pay your required Premiums by the due date, we may terminate your membership as described in this "Termination for nonpayment of Cal-COBRA Premiums" section. If you intend to terminate your membership, be sure to notify us as described under "How you may terminate your Cal-COBRA coverage" in this "Cal-COBRA" section, as you will be responsible for any Premiums billed to you unless you let us know before the first of the coverage month that you want us to terminate your coverage.

Your Premium payment for the upcoming coverage month is due on the first day of that month. If we do not receive full Premium payment on or before the first 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 the memberships of everyone in your Family for nonpayment if we do not receive the required Premiums within 30 days after the date of the Late Notice
- The amount of Premiums that are due
- The specific date and time when the memberships of everyone in your Family will end if we do not receive the Premiums

If we terminate your Cal-COBRA coverage because we did not receive the required Premiums when due, your membership will end at 11:59 p.m. on the 30th day after the date of the Late Notice. Your coverage will continue during this 30 day grace period, but upon termination you will be responsible for paying all past due Premiums, including the Premiums for this grace period.

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 of the Late Notice. The Termination Notice will include the following information:

- A statement that we have terminated the memberships of everyone in your Family for nonpayment of Premiums
- The specific date and time when the memberships of everyone in your Family ended
- The amount of Premiums that are due
- Information explaining whether or not you can reinstate your memberships
- Your appeal rights

If we terminate your membership, you are still responsible for paying all amounts due.

Reinstatement of your membership after termination for nonpayment of Cal-COBRA Premiums. If we terminate your membership for nonpayment of Premiums, we will permit reinstatement of your membership three times during any 12-month period if we receive the amounts owed within 15 days of the date of the Termination Notice. We will not reinstate your membership if you do not obtain reinstatement of your terminated membership within the required 15 days, or if we terminate your membership for nonpayment of Premiums more than three times in a 12-month period.

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

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

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

Coverage for a Disabling Condition

If you became Totally Disabled while you were a Member under your Group's *Agreement* with us and while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates and is not renewed, we will cover Services for your totally

disabling condition until the earliest of the following events occurs:

- 12 months have elapsed since your Group's *Agreement* with us terminated
- You are no longer Totally Disabled
- Your Group's *Agreement* with us is replaced by another group health plan without limitation as to the disabling condition

Your coverage will be subject to the terms of this *Evidence of Coverage*, including Copayments and Coinsurance, but we will not cover Services for any condition other than your totally disabling condition.

For Subscribers and adult Dependents, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months, and makes the person unable to engage in any employment or occupation, even with training, education, and experience.

For Dependent children, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the illness or injury makes the child unable to substantially engage in any of the normal activities of children in good health of like age.

To request continuation of coverage for your disabling condition, you must call our Member Service Contact Center within 30 days after your Group's *Agreement* with us terminates.

Leave of Absence

If you qualify for continuing group membership by completion of HBD Form 21, you should contact your Health Benefits Officer who will help you make the necessary changes in your enrollment while you are on a leave of absence.

If you are paying your monthly premiums using the coupon payment book, please send your payment to the following address:

Kaiser Permanente
P.O. Box 7004
Anaheim, CA 92850-7004

If you receive a billing statement for your monthly premiums, please send your payment to the following address:

Kaiser Permanente
P.O. Box 7027
Anaheim, CA 92850-7027

Please note that it is very important to make the necessary enrollment changes and establish your account before you begin making monthly payments. Contact your Health Benefits Officer to make the necessary enrollment changes prior to your leave of absence. If you have additional questions, please call our Member Service Contact Center.

Continuation of Coverage under an Individual Plan

If you want to remain a Health Plan member when your Group coverage ends, you might be able to enroll in one of our Kaiser Permanente for Individuals and Families plans. The premiums and coverage under our individual plan coverage are different from those under this *Evidence of Coverage*.

If you want your individual plan coverage to be effective when your Group coverage ends, you must submit your application within the special enrollment period for enrolling in an individual plan due to loss of other coverage. Otherwise, you will have to wait until the next annual open enrollment period.

To request an application to enroll directly with us, please go to kp.org or call our Member Service Contact Center. For information about plans that are available through Covered California, see "Covered California" below.

Covered California

U.S. citizens or legal residents of the U.S. can buy health care coverage from Covered California. This is California's health insurance marketplace (the Exchange). You may apply for help to pay for premiums and copayments but only if you buy coverage through Covered California. This financial assistance may be available if you meet certain income guidelines. To learn more about coverage that is available through Covered California, visit www.CoveredCA.com or call Covered California at 1-800-300-1506 (TTY users call 711).

Miscellaneous Provisions

Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient

administration of your Group's *Agreement*, including this *Evidence of Coverage*.

Advance directives

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

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

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

Agreement binding on Members

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

Amendment of Agreement

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

Applications and statements

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

Assignment

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

Attorney and advocate fees and expenses

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

Claims review authority

We are responsible for determining whether you are entitled to benefits under this *Evidence of Coverage* and we have the discretionary authority to review and evaluate claims that arise under this *Evidence of Coverage*. We conduct this evaluation independently by interpreting the provisions of this *Evidence of Coverage*. We may use medical experts to help us review claims. If coverage under this *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 *Evidence of Coverage*.

Governing law

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

Group and Members not our agents

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

No waiver

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

Nondiscrimination

We do not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, language, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, or genetic information.

Notices

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

Note: When we tell your Group about changes to this *Evidence of Coverage* or provide your Group other information that affects you, your Group is required to

notify the Subscriber within 30 days after receiving the information from us.

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. You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means.

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

This is only a brief summary of some of our key privacy practices. **OUR NOTICE OF PRIVACY PRACTICES, 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 Contact Center. You can also find the notice at a 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 Contact 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

Helpful Information

How to Obtain this Evidence of Coverage in Other Formats

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

Your Guidebook to Kaiser Permanente Services (Your Guidebook)

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

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

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

of *Your Guidebook* by visiting our website at kp.org or by calling our Member Service Contact Center.

Online Tools and Resources

Here are some tools and resources available on our website at kp.org:

- A directory of Plan Facilities and Plan Physicians
- Tools you can use to email your doctor's office, view test results, refill prescriptions, and schedule routine appointments
- Health education resources
- Appointments and advice phone numbers

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**
1-800-788-0616 (Spanish)
1-800-757-7585 (Chinese dialects)
711 (TTY for the deaf, hard of hearing, or speech impaired)

24 hours a day, seven days a week (except closed holidays)

Interpreter services available during all business hours at no cost to you.

Write Member Services Department at a Plan Facility (refer to *Your Guidebook* for addresses)

Website kp.org

Authorization for Post-Stabilization Care

To request prior authorization for Post-Stabilization Care as described under "Emergency Services" in the "Emergency Services and Urgent Care" section:

Call **1-800-225-8883** or the notification telephone number on your Kaiser Permanente ID card

711 (TTY for the deaf, hard of hearing, or speech impaired)

24 hours a day, seven days a week

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, Copayments, and Coinsurance" 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**

711 (TTY for the deaf, hard of hearing, or speech impaired)

24 hours a day, seven days a week (except closed 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, Copayments, and Coinsurance" section, or if you need to submit other information that we request about your claim, send it to our Claims Department:

Write *For Northern California Members:*

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

For Southern California Members:

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

- If you have coverage with another plan or with 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 must pay the full price for noncovered Services

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.

Payment Responsibility

This "Payment Responsibility" section briefly explains who is responsible for payments related to the health care coverage described in this *Evidence of Coverage*.

Payment responsibility is more fully described in other sections of the *Evidence of Coverage* as described below:

- Your Group is responsible for paying Premiums, except that you are responsible for paying Premiums if you have COBRA or Cal-COBRA (refer to "Premiums" in the "Premiums, Eligibility, and Enrollment" section and "COBRA" and "Cal-COBRA" under "Continuation of Group Coverage" in the "Continuation of Membership" section)
- Your Group may require you to contribute to Premiums (your Group will tell you the amount and how to pay)
- You are responsible for paying your Copayment or Coinsurance for covered Services (refer to the "Benefits, Copayments, and Coinsurance" 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)



Kaiser Foundation Health Plan, Inc.
Northern California Region

Combined Chiropractic and Acupuncture Services Amendment Evidence of Coverage

January 1, 2017, through December 31, 2017

ASH Plans Customer Service Department
Monday through Friday, 5 a.m. to 6 p.m.
1-800-678-9133 (TTY users call **711**) toll free
www.ashlink.com/ash/kp

ASH Plan Benefit Summary

Professional Services (Plan Provider office visits)	You Pay
Chiropractic and acupuncture office visits (up to a combined total of 20 visits per 12-month period)	\$15 per visit
Other	You Pay
X-rays and laboratory tests that are covered Chiropractic Services	No charge
Chiropractic appliances	Amounts in excess of the \$50 Allowance

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Copayments, Coinsurance, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits Copayments and Coinsurance amounts. For a complete explanation, please refer to the "Covered Services" and "Exclusions" sections.

Introduction

This document amends your Kaiser Foundation Health Plan, Inc. (Health Plan) Evidence of Coverage to add coverage for Chiropractic Services and Acupuncture Services as described in this Combined Chiropractic and Acupuncture Services Amendment ("Amendment"). All provisions of the *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" section, or for Kaiser Permanente Senior Advantage 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, Copayments, and Coinsurance"

Kaiser Foundation Health Plan, Inc. contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to make the ASH Plans network of Participating Providers available to you. When you need chiropractic care or acupuncture, you have direct access to more than 3,400 licensed chiropractors and more than 2,000 licensed acupuncturists in California. You can obtain covered Services from any Participating Provider without a referral from a Plan Physician. Your Copayment or Coinsurance is due when you receive covered Services.

Definitions

In addition to the terms defined in the "Definitions" section of your Health Plan *Evidence of Coverage*, the following terms, when capitalized and used in any part of this Amendment, have the following meanings:

Acupuncture Services: The stimulation of certain points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions (including adjunctive therapies, such as acupressure, moxibustion, or breathing techniques, when provided during the same course of treatment and in conjunction with acupuncture) when provided by an acupuncturist for the treatment of your Neuromusculoskeletal Disorder, nausea (such as nausea related to chemotherapy, postsurgery pain, or pregnancy), or pain (such as lower back pain, shoulder pain, joint pain, or headaches).

ASH Plans: American Specialty Health Plans of California, Inc., a California corporation.

Chiropractic Services: Services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic appliances) for the treatment of your Neuromusculoskeletal Disorder.

Emergency Acupuncture Services: Covered Acupuncture Services provided for the treatment of a Neuromusculoskeletal Disorder, nausea, or pain, which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable person could expect the absence of immediate Acupuncture Services to result in serious jeopardy to your health or body functions or organs.

Emergency Chiropractic Services: Covered Chiropractic Services provided for the treatment of a Neuromusculoskeletal Disorder which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable person could 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 Provider: A provider other than a Participating Provider.

Participating Provider: An acupuncturist who is licensed to provide acupuncture services in California and who has a contract with ASH Plans to provide Medically Necessary Acupuncture Services to you. , or 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 Providers is available on the ASH Plans website at www.ashlink.com/ash/kp or from the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**). The list of Participating Providers is subject to change at any time, without notice. If you have questions, please call the ASH Plans Customer Service Department.

Treatment Plan: One of the following, depending on whether the Treatment Plan is for Chiropractic Services or Acupuncture Services:

- 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 adjunctive therapies that are Medically Necessary Chiropractic Services for you
- A proposed course of treatment for your Neuromusculoskeletal Disorder, nausea, or pain, which will include a specific number of visits for acupuncture (including adjunctive therapies such as acupressure, moxibustion, or breathing techniques when provided during the same course of treatment and in conjunction with acupuncture) that are Medically Necessary Acupuncture Services for you

Urgent Acupuncture Services: Acupuncture Services that meet all of the following requirements:

- They are necessary to prevent serious deterioration of your health, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy
- They cannot be delayed until you return to the Service Area

Urgent Chiropractic Services: Chiropractic Services that meet all of the following requirements:

- They are necessary to prevent serious deterioration of your health resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy
- They cannot be delayed until you return to the Service Area

Participating Providers

Please read the following information so you will know from whom or what group of providers you may receive Services covered under this Amendment.

ASH Plans contracts with Participating Providers, and other licensed providers to provide the Services covered under this Amendment (including laboratory tests, X-rays, and chiropractic appliances). You must receive Services covered under this Amendment from a Participating Provider or another licensed provider with which ASH contracts to provide covered care, except for Services covered under "Emergency and urgent Services covered under this Amendment" in the "Covered Services" section and Services that are not available

from contracted providers and that are authorized in advance by ASH Plans.

How to Obtain Services

To obtain Services covered under this Amendment, call a Participating Provider to schedule an initial examination. Your Participating Provider will request any required medical necessity determinations. An ASH Plans clinician in the same or similar specialty as the provider of Services under review will determine whether the Services are or were Medically Necessary Services.

Decision time frames

The ASH Plans' clinician will make the authorization decision within the time frame appropriate for your condition, but no later than five business days after receiving all of 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 ASH Plans 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 Participating Provider will be informed in writing about the additional information, testing, or specialist that is needed, and the date that ASH Plans expects to make a decision.

Your Participating Provider will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your Participating Provider will be informed of the scope of the authorized Services. If ASH Plans does not authorize all of the Services, ASH Plans will send you a written decision and explanation, including the rationale for the decision and the criteria used to make the decision, within two business days after the decision is made. The letter will also include information about your appeal rights, which are described in the "Coverage Decisions, Appeals, and Complaints" section of your Health Plan *Evidence of Coverage* for Kaiser Permanente Senior Advantage Members, and "Dispute Resolution" section of your Health Plan *Evidence of Coverage* for all other Members. Any written criteria that ASH Plans uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request. If you have questions or concerns, please contact ASH Plans or Kaiser Permanente as described under "Customer Service" in this Amendment.

Covered Services

We cover the Services listed in this "Covered Services" section, subject to exclusions described in the "Exclusions" section, only if all of the following conditions are satisfied:

- You are a Member on the date that you receive the Services
- ASH Plans has determined that the Services are Medically Necessary, except for:
 - ◆ the initial examination described under "Office Visits" in this "Covered Services" section
 - ◆ Services covered under "Emergency and urgent Services covered under this Amendment" in this "Covered Services" section
- You receive the Services from Participating Providers or other licensed providers with which ASH contracts to provide covered care, except for:
 - ◆ Services covered under "Emergency and urgent Services covered under this Amendment" in this "Covered Services" section
 - ◆ Services that are not available from Participating Providers or other licensed providers with which ASH contracts to provide covered care and that are authorized in advance by ASH Plans

When you receive covered Services, you must pay the Copayment or Coinsurance listed in this "Covered Services" section. If you receive Services that are not covered under this Amendment, you may be liable for the full price of those Services.

Note: If Charges for Services are less than the Copayment described in this "Covered Services" section, you will pay the lesser amount.

The Copayment or Coinsurance you pay for Services covered under this Amendment does not apply toward any Plan Deductible or Plan Out-of-Pocket Maximum described in your Health Plan *Evidence of Coverage*.

If you have questions about your Copayment or Coinsurance for specific Services that you are scheduled to receive or that your provider orders during a visit or procedure, please call the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**) weekdays from 5 a.m. to 6 p.m.

Coverage of Acupuncture Services under this Amendment is different from the coverage of acupuncture Services under your Health Plan *Evidence of Coverage*. You do not need a referral to get covered Services under this Amendment, but covered Services

and your Copayment or Coinsurance may differ from those under your Health Plan *Evidence of Coverage*. If you receive acupuncture Services for which you have a referral (as described under "Getting a Referral" in the "How to Obtain Services" section of the *Evidence of Coverage*), then unless you tell us otherwise, we will assume that you are using your coverage under your Health Plan *Evidence of Coverage*.

If you are a Kaiser Permanente Senior Advantage Member, please refer to your Health Plan *Evidence of Coverage* for information about the chiropractic Services that we cover in accord with Medicare guidelines, which are separate from the Services covered under this Amendment.

Office visits

We cover up to a combined total of 20 of the following types of office visits per 12 month period at a **\$15**

Copayment per visit:

- **Initial chiropractic examination:** An examination performed by a Participating Provider 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 Chiropractic Services from a Participating Provider in the same 12 month period for your Neuromusculoskeletal Disorder
- **Subsequent chiropractic office visits:** Subsequent Participating Provider 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
- **Initial acupuncture examination:** An examination performed by a Participating Provider to determine the nature of your problem (and, if appropriate, to prepare a Treatment Plan), and to provide Medically Necessary Acupuncture Services. We cover an initial examination only if you have not already received covered Acupuncture Services from a Participating Provider in the same 12 month period for your Neuromusculoskeletal Disorder, nausea, or pain
- **Subsequent acupuncture office visits:** Subsequent Participating Provider office visits for Medically Necessary Acupuncture Services, and a re-examination to assess the need to continue, extend, or change a Treatment Plan

Each office visit counts toward any visit limit, if applicable.

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 Provider provides the Services or refers you to another licensed provider with which ASH contracts to provide covered Services.

Chiropractic appliances

We provide a **\$50 Allowance per 12 month period** 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 Provider 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 the Plan Out-of-Pocket Maximum described in your Health Plan *Evidence of Coverage*). 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

You may request a second opinion in regard to covered Services by contacting another Participating Provider. Your visit to another Participating Provider for a second opinion generally will count toward any visit limit, if applicable. A Participating Provider may also request a second opinion in regard to covered Services by referring you to another Participating Provider in the same or similar specialty. When you are referred by a Participating Provider to another Participating Provider for a second opinion, your visit to the other Participating Provider will not count toward any visit limit, if applicable. You have a right to a second opinion. If you have requested a second opinion and you have not received it or you believe it has not been authorized, you can file a grievance as described under "Grievances" in this Amendment.

Emergency and urgent Services covered under this Amendment

Emergency and urgent chiropractic Services. We cover Emergency Chiropractic Services and Urgent Chiropractic Services provided by a Participating Provider or a Non-Participating Provider at a **\$15**

Copayment per visit. We do not cover follow-up or continuing care from a Non-Participating Provider unless ASH Plans has authorized the Services in advance. Also, we do not cover Services from a Non-Participating Providers that ASH Plans determines are not Emergency Chiropractic Services or Urgent Chiropractic Services.

Emergency and urgent acupuncture Services. We cover Emergency Acupuncture Services and Urgent Acupuncture Services provided by a Participating Provider or a Non-Participating Provider at a **\$15 Copayment per visit.** We do not cover follow-up or continuing care from a Non-Participating Provider unless ASH Plans has authorized the Services in advance. Also, we do not cover Services from a Non-Participating Provider that ASH Plans determines are not Emergency Acupuncture Services or Urgent Acupuncture Services.

How to file a claim. As soon as possible after receiving Emergency Chiropractic Services or Urgent Chiropractic Services or Emergency Acupuncture Services or Urgent Acupuncture 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**) or visit the ASH Plans website at www.ashlink.com. You must send the completed claim form to:

ASH Plans
P.O. Box 509002
San Diego, CA 92150-9002

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 Amendment regardless of whether the services are within the scope of a provider's license or certificate:

- Acupuncture services for conditions other than Neuromusculoskeletal Disorders, nausea, and pain
- Services for asthma or addiction, such as nicotine addiction
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Thermography
- Experimental or investigational Services. If coverage for a Service is denied because it is experimental or investigational and you want to appeal the denial, refer to your Health Plan *Evidence of Coverage* for information about the appeal process

- CT scans, MRIs, PET scans, bone scans, nuclear medicine, and any other type of diagnostic imaging or radiology other than X-rays covered under the "Covered Services" section of this 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
- Acupuncture performed with reusable needles
- 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 Amendment
- Drugs and medicines, including non-legend or proprietary drugs and medicines
- Services you receive outside the state of California, except for Services covered under "Emergency and Urgent Services covered under this Amendment" in the "Covered Services" section
- Hospital services, anesthesia, manipulation under anesthesia, and related services
- For Chiropractic Services, adjunctive therapy not associated with spinal, muscle, or joint manipulations
- For Acupuncture Services, adjunctive therapies unless provided during the same course of treatment and in conjunction with acupuncture
- Dietary and nutritional supplements, such as 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
- Services provided by an acupuncturist that are not within the scope of licensure for an acupuncturist licensed in California
- Maintenance care (services provided to Members whose treatment records indicate that they have reached maximum therapeutic benefit)

Customer Service

If you have a question or concern regarding the Services you received from a Participating Provider or any other licensed provider with which ASH contracts to provide

covered Services, you may call the ASH Plans Customer Service Department 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
Customer Service Department
P.O. Box 509002
San Diego, CA 92150-9002

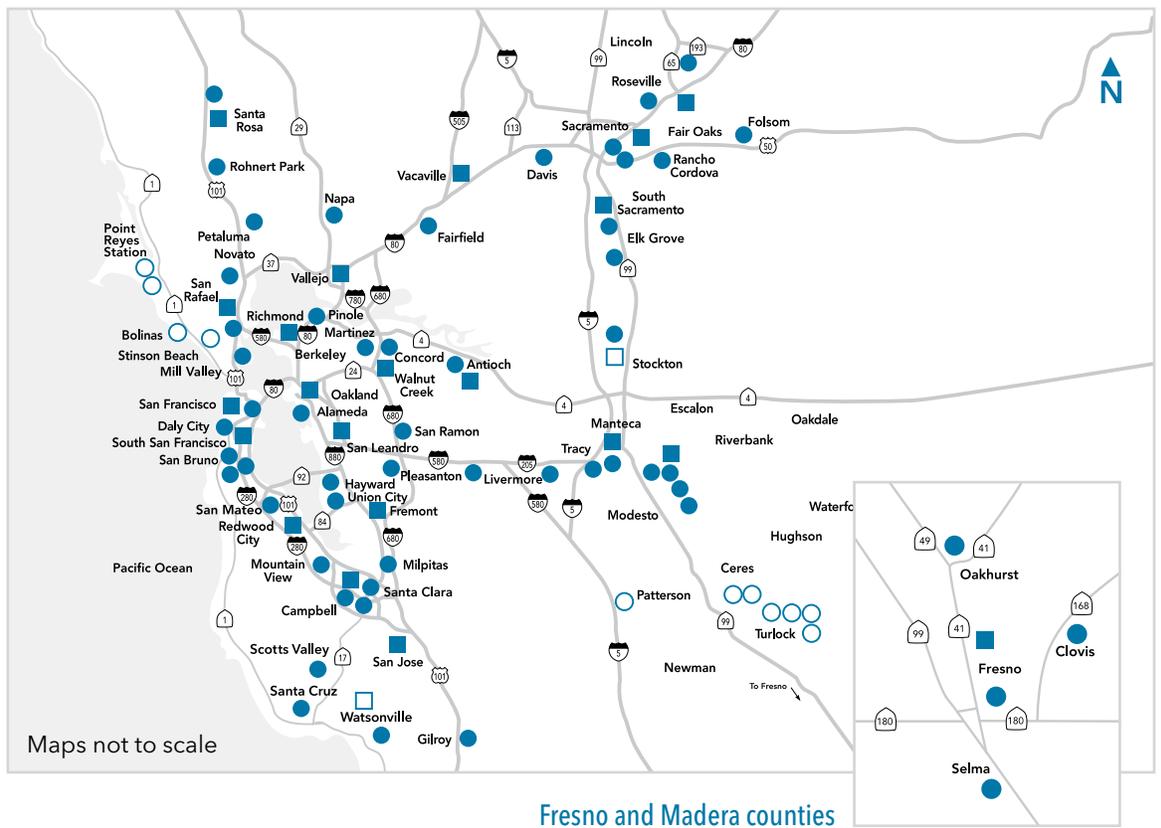
Grievances

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. If you are a Kaiser Permanente Senior Advantage Member, you may submit your grievance orally or in writing to Kaiser Permanente as described in the "Coverage Decisions, Appeals, and Complaints" section of your Health Plan *Evidence of Coverage*. Otherwise, you may submit your grievance orally or in writing to Kaiser Permanente as described in the "Dispute Resolution" section of your Health Plan *Evidence of Coverage*.

Northern California

Legend:

- Kaiser Permanente medical centers (hospital and medical offices)
- Kaiser Permanente medical offices
- Affiliated plan hospitals
- Affiliated medical offices



Southern California

Legend:

- Kaiser Permanente medical centers (hospital and medical offices)
- Kaiser Permanente medical offices
- Affiliated plan hospitals
- Affiliated medical offices

