



**Kaiser Foundation Health Plan, Inc.  
Northern California Region**

*A nonprofit corporation*

## **Group Agreement for EL DORADO COUNTY**

Purchaser ID: 34936 Contract: 1 Version: 48

*July 1, 2010, through June 30, 2011*

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## Introduction

This Group Agreement (*Agreement*), including the *Evidence of Coverage (EOC)* document(s) listed below, the group application that Group submitted to Health Plan, and any amendments to any of them, all of which are incorporated into this *Agreement* by reference, constitute the contract between Kaiser Foundation Health Plan, Inc., (Health Plan) and EL DORADO COUNTY (Group). In this *Agreement*, some capitalized terms have special meaning; please see the "Definitions" section in the *EOC* document(s) for terms you should know. Pursuant to this *Agreement*, Health Plan will provide covered Services to Members in accord with the following *EOC* document(s):

<u>Product name</u>	<u>Contract option name</u>	<u>EOC #</u>
Kaiser Permanente Senior Advantage with Part D	Senior Advantage	1
Kaiser Permanente Senior Advantage with Part D (MSP)	Working Aged	2
American Specialty Health Plans Chiropractic Plan	HMO Chiro	3
Kaiser Permanente Traditional Plan	Traditional Plan	5

## Term of Agreement and Renewal

### Term of Agreement

Unless terminated as set forth in the "Termination of *Agreement*" section, this *Agreement* is effective from July 1, 2010, through June 30, 2011.

### Renewal

This *Agreement* does not automatically renew. If Group complies with all of the terms of this *Agreement*, Health Plan will offer to renew the *Agreement*, upon 30 days prior written notice to Group, by doing one of the following:

- Providing Group with a new *Group Agreement* to become effective immediately after termination of this *Agreement*
- Extending the term of this *Agreement* and making other changes pursuant to "Amendments Effective on July 1 (Anniversary Date)" in the "Amendment of *Agreement*" section
- Sending Group a renewal notice, which will include a summary of changes to this *Agreement* that will become effective immediately after termination of this *Agreement*. The new *Group Agreement* will incorporate the changes summarized in the renewal notice. Health Plan will send Group the new *Group Agreement* after Group confirms it wants to make additional changes or 60 days after Group's Anniversary Date, if Group does not confirm

If Group does not renew the *Agreement*, Group must give Health Plan written notice as described under "Termination on Notice" or "Termination due to Nonacceptance of Amendments" in the "Termination of *Agreement*" section.

## Amendment of Agreement

### Amendments Effective on July 1 (Anniversary Date)

Upon 30 days prior written notice to Group, Health Plan may extend the term of this *Agreement* and make other changes by amending this *Agreement* effective July 1 (the Anniversary Date).

## **Amendments Related to Government Approval**

If Health Plan notified Group that Health Plan had not received all necessary governmental approvals related to this *Agreement*, Health Plan may amend this *Agreement* by giving written notice to Group after receiving all necessary governmental approvals. Any such government-approved provisions go into effect on July 1, 2010 (unless the government requires a later effective date).

## **Amendment Due to Medicare Changes**

Health Plan contracts on a calendar year basis with the Centers for Medicare & Medicaid Services (CMS) to offer Kaiser Permanente Senior Advantage. Health Plan may amend this *Agreement* to change any Kaiser Permanente Senior Advantage *EOCs* and Premiums effective January 1, 2011 (unless the federal government requires or allows a different effective date). The amendment may include an increase or decrease in Premiums and benefits (including Member Cost Sharing and any Medicare Part D coverage level thresholds). Health Plan will give Group written notice of any such amendment.

In addition, Health Plan may amend this *Agreement* at any time by giving written notice to Group, in order to increase any benefits of any Medicare product approved by the Centers for Medicare & Medicaid Services (CMS).

## **Amendment Due to Tax or Other Charges**

If a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Health Plan or Plan Providers (or any of their activities), then upon 30 days prior written notice, Health Plan may increase Group's Premiums to include Group's share of the new or increased tax or charge. Group's share will be determined by dividing the number of Members enrolled through Group by the total number of members enrolled in the Northern California Region.

## **Other Amendments**

Health Plan may amend this *Agreement* at any time by giving written notice to Group, in order to address any law or regulatory requirement, which may include an increase in Premiums to reflect an increase in costs to Health Plan or Plan Providers (Health Plan will give Group 30 days prior written notice of any such increase in Premiums).

## **Acceptance of Amendments**

All amendments are deemed accepted by Group unless Group gives Health Plan written notice of nonacceptance within 15 days after the date of Health Plan's amendment notice, in which case this *Agreement* will terminate pursuant to "Termination due to Nonacceptance of Amendments" in the "Termination of *Agreement*" section.

## **Termination of Agreement**

This *Agreement* will terminate under any of the conditions listed below. All rights to benefits under this *Agreement* end on the termination date, except as expressly provided in the "Termination of Membership" or "Continuation of Membership" sections of an *Evidence of Coverage*. The termination date is the first day when this *Agreement* is no longer in effect (for example, if the termination date is January 1, 2010, the last minute this *Agreement* was in effect was at 11:59 p.m. on December 31, 2009).

If Health Plan terminates this *Agreement*, Health Plan will give Group written notice. Within five business days of receipt, Group will mail to each Subscriber a legible copy of the notice and will give Health Plan proof of that mailing and of the date thereof.

### **Termination on Notice**

Group may terminate this *Agreement* effective July 1 (the Anniversary Date) by giving at least 15 days prior written notice to Health Plan and remitting all amounts payable relating to this *Agreement*, including Premiums, for the period prior to the termination date.

### **Termination Due to Nonacceptance of Amendments**

All amendments are deemed accepted by Group unless Group gives Health Plan written notice of nonacceptance within 15 days after the date of Health Plan's amendment notice and remits all amounts payable related to this *Agreement*, including Premiums, for the period prior to the amendment effective date. This *Agreement* will terminate the day before the effective date of the amendment.

### **Termination for Nonpayment**

If Group fails to make any past-due payment within 15 days after Health Plan's initial written notice to Group of the amount payable, Health Plan may terminate this *Agreement* immediately by giving written notice to Group, and Group is liable for all unpaid Premiums up to the termination date.

### **Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information**

Health Plan may terminate this *Agreement* upon 15 days prior written notice to Group, if Group commits fraud or intentionally furnishes incorrect or incomplete material information to Health Plan.

### **Termination for Violation of Contribution or Participation Requirements**

Health Plan may terminate this *Agreement* upon 15 days prior written notice to Group, if Group fails to comply with Health Plan's participation or contribution requirements (including those discussed in the "Contribution and Participation Requirements" section).

### **Termination for Discontinuance of a Product or all Products within a Market**

Health Plan may terminate a particular product or all products offered in a small or large group market as permitted or required by law. If Health Plan discontinues offering a particular product in a market, Health Plan may terminate this *Agreement* with respect to that product upon 90 days prior written notice to Group. Health Plan will offer Group another product that it makes available to groups in the small or large group market, as applicable. If Health Plan discontinues offering all products to groups in a small or large group market, as applicable, Health Plan may terminate this *Agreement* upon 180 days prior written notice to Group and Health Plan will not offer any other product to Group. A "product" is a combination of benefits and services that is defined by a distinct *Evidence of Coverage*.

## **Contribution and Participation Requirements**

No change in Group's contribution or participation requirements listed below is effective for purposes of this *Agreement* unless Health Plan consents in writing. As a condition to consenting to Group's revised contribution and participation requirements, Health Plan may require Group to agree to amend the Premiums, benefits, or other provisions of this *Agreement*.

Group must:

- Contribute to all health care coverage available through Group on a basis that does not financially discriminate against Health Plan or against people who choose to enroll in Health Plan. For each Family, Group's contribution must be an

amount that is at least 50 percent of the premium required for a single Subscriber for the coverage in which the Subscriber is enrolled

- Ensure that:
  - ◆ all employees enrolled in Health Plan work at least 20 hours per week unless Health Plan agrees otherwise in writing
  - ◆ all employees enrolled in Health Plan are covered by workers' compensation or the employer's liability benefits, unless not required by law to be covered
  - ◆ at least 75 percent of eligible employees are covered by a group health care plan
  - ◆ all Traditional Plan Subscribers live or work inside our Service Area when they enroll (except that groups who chose not to have a "live or work" eligibility rule must ensure that all Traditional Plan Subscribers live inside our Service Area when they enroll)
  - ◆ at least one employee, proprietor, or partner who lives or works inside the Service Area is eligible to enroll as a Subscriber
  - ◆ the number of Subscribers enrolled under this *Agreement* does not fall below the greater of five employees or five percent of the total number of eligible employees
  - ◆ the ratio between the number of Subscribers and the total number of people who are eligible to enroll as Subscribers will not drop by 20 percent or more. For the purpose of computing this percentage requirement, Group may include subscribers and those eligible to enroll as subscribers under all other agreements between Group and Health Plan and all other Regions
- Hold an annual open enrollment period during which all eligible people may enroll in Health Plan or in any other health care plan available through Group. Also, Group must not hold open enrollment for 2011 until Group receives its 2011 group agreement Premium and coverage information from Health Plan. If Group holds the open enrollment without receiving 2011 group agreement Premium and coverage information, Health Plan may change Premiums and coverage (including benefits and Cost Sharing) when it offers to renew Group's *Agreement* as described under "Renewal" in the "Term of *Agreement* and Renewal" section
- Meet all applicable legal and contractual requirements, such as:
  - ◆ distribute the *Disclosure Form* to Subscribers and potential Subscribers and the *Evidence of Coverage* to Subscribers in accord with applicable laws, including the Medicare-as-Secondary-Payer laws
  - ◆ adhere to all requirements set forth in the applicable *Evidence of Coverage*
  - ◆ obtain Health Plan's prior written approval of any Group eligibility requirements that are not stated in the applicable *Evidence of Coverage*
  - ◆ use Member enrollment application forms that are provided or approved by Health Plan as described under "Enrollment Application Requirements" in the "Miscellaneous Provisions" section
  - ◆ comply with CMS requirements governing enrollment in, and disenrollment from, Kaiser Permanente Senior Advantage
- Meet all Health Plan requirements set forth in the "Rate Assumptions and Requirements" section of the *Rate Proposal* document
- Offer enrollment in Health Plan to all eligible people on conditions no less favorable than those for any other health care plan available through Group
- Permit Health Plan to examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement*

## Miscellaneous Provisions

### Assignment

Health Plan may assign this *Agreement*. Group may not assign this *Agreement* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Health Plan's prior written consent. This *Agreement* shall be binding on the successors and permitted assignees of Health Plan and Group.

### Attorney Fees and Costs

If Health Plan or Group institutes legal action against the other to collect any sums owed under this *Agreement*, the party that substantially prevails will be reimbursed for its reasonable litigation expenses, including attorneys' fees, by the other party.

### Confidential Information about Health Plan or its Affiliates

For the purposes of this "Confidential Information about Health Plan or its Affiliates" section, "Confidential Information" means any oral, written, or electronic information concerning Health Plan or its affiliates, if the information either is marked "confidential" or is by its nature proprietary or non-public, except that it does not include any of the following:

- Information that is or becomes available to the public other than as a result of disclosure by Group or its employees, advisors, or representatives
- Information that was available to Group or within its knowledge before Health Plan disclosed it to Group
- Information that becomes available to Group from a source other than Health Plan, but only if that source is not bound by a confidentiality agreement with Health Plan

If Group receives any Confidential Information, it will use that information only to evaluate Health Plan and actual or proposed group agreements with Health Plan. Group will ensure that the information is not disclosed to anyone other than a limited number of Group's employees and advisors, and only to the extent necessary in connection with the evaluation of Health Plan and actual or proposed group agreements with Health Plan. Group will inform any such employees and advisors that the information is confidential and that they must treat it confidentially.

Upon Health Plan's request Group will promptly return to Health Plan all Confidential Information, and will destroy any other copies and any notes or other Group documents about the information.

If Group is requested or required (by oral questions, interrogatories, request for information or documents, subpoena, civil investigative demand, or similar process) to disclose any Confidential Information, Group will give Health Plan prompt notice of the request or requirement, and Group will cooperate with Health Plan in seeking to legally avoid the disclosure. If, in the absence of a protective order, Group is legally compelled, in the opinion of its counsel, to disclose any of the information, Health Plan either will seek and obtain appropriate protective orders against the disclosure or will be deemed to waive Group's compliance with the provisions of this "Confidential Information about Health Plan or its Affiliates" section to the extent necessary to satisfy the request or requirement.

Group understands (and will inform any employees and advisors who receive Confidential Information) that United States securities laws prohibit anyone who has material non-public information about a company from buying or selling that company's securities in reliance upon that information or from communicating the information to any other person or entity under circumstances in which it is reasonably foreseeable that the person or entity is likely to buy or sell that company's securities in reliance upon the information. Group agrees that it and its affiliates, associates, employees, agents, and advisors will not rely on any Confidential Information in directly or indirectly buying or selling any Health Plan securities.

Monetary damages would not be a sufficient remedy for any breach or threatened breach of this "Confidential Information about Health Plan or its Affiliates" section. Health Plan will be entitled to equitable relief by way of injunction or specific

performance if Group or any of its officers, directors, employees, attorneys, accountants, agents, advisors, or representatives breach, or threaten to breach, any of the provisions of this "Confidential Information about Health Plan or its Affiliates" section.

Group's obligations under this "Confidential Information about Health Plan or its Affiliates" section will continue indefinitely and will survive the termination or expiration of this *Agreement*.

### **Contract Providers**

Health Plan will give Group written notice within a reasonable time of any termination or breach of contract by, or inability to perform of, any health care provider that contracts with Health Plan if Group may be materially and adversely affected thereby.

### **Delegation of Claims Review**

Group delegates to Health Plan the discretion to determine whether a Member is entitled to benefits under this *Agreement*. In making these determinations, Health Plan has discretionary authority to review claims in accord with the procedures contained in this *Agreement* and to construe this *Agreement* to determine whether the Member is entitled to benefits. For health benefit plans that are subject to the Employee Retirement Income Security Act (ERISA), Health Plan is a named fiduciary to review claims under this *Agreement*.

### **Enrollment Application Requirements**

Group must use enrollment application forms that are provided by Health Plan. If Group wants to use a different form or system for enrolling Members, Group must obtain Health Plan's approval of the form or system. Other forms and systems include a "universal" enrollment application form, interactive voice recording (IVR) enrollment system, or intranet online enrollment system. All forms and systems must meet Health Plan requirements for enrolling Members, including disclosure of binding arbitration in accord with Section 1363.1 of the California Health and Safety Code and other applicable law. Group's Health Plan account manager can provide Group with Health Plan's current requirements for enrollment application forms and systems.

### **Governing Law**

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

### **Member Information**

Group will inform Subscribers of eligibility requirements for Members and when coverage becomes effective and terminates.

When Health Plan notifies Group about changes to this *Agreement* or provides Group other information that affects Members, Group will disseminate the information to Subscribers by the next regular communication to them, but in no event later than 30 days after Group receives the information.

### **No Waiver**

Health Plan's failure to enforce any provision of this *Agreement* will not constitute a waiver of that or any other provision, or impair Health Plan's right thereafter to require Group's strict performance of any provision.



## **Notices**

Notices must be sent to the addresses listed below. Health Plan or Group may change its addresses for notices by giving written notice to the other. All notices are deemed given when delivered in person or deposited in a U.S. Postal Service receptacle for the collection of U.S. mail.

### **Notices from Health Plan to Group will be sent to:**

LISA HOAAS, SR. RISK ANALYST  
EL DORADO COUNTY  
330 FAIR LN  
PLACERVILLE, CA 95667-4103

**Note:** When Health Plan sends Group a new (renewed) *Agreement*, Health Plan will enclose a summary of changes that discusses the changes Health Plan has made to the *Group Agreement*. Groups that want information about changes before receiving the *Agreement* may request advance information from Group's Health Plan account manager. Also, if Group designates a third party in writing (for example, "Broker of Record" statements), Health Plan may send the advance information to the third party rather than to Group (unless Group requests a copy too).

### **Notices from Group to Health Plan must be sent to:**

Kaiser Permanente  
1950 Franklin Street  
Oakland, CA 94612  
Attn: Jerry Fleming, Senior Vice President and Health Plan Manager

## **Reporting Membership Changes and Retroactivity**

Group must report membership changes (including sending appropriate membership forms) within the time limit for retroactive changes. The time limit for retroactive membership changes is the calendar month when Health Plan's California Service Center receives Group's notification of the change plus the previous 2 months.

Health Plan's *Purchaser Handbook* includes the details about how to report membership changes. Group's Health Plan account manager can provide Group with a *Purchaser Handbook* if Group does not have one.

## **Social Security and Tax Identification Numbers**

Within 60 days after Health Plan sends Group a written request, Group will send Health Plan a list of all Members covered under this Agreement, along with the following:

- The Social Security number of the Member
- The tax identification number of the employer of the Subscriber in the Member's Family
- Any other information that Health Plan is required by law to collect

## **Premiums**

Only Members for whom Health Plan (or its designee) has received the appropriate Premium payment listed below are entitled to coverage under this *Agreement*, and then only for the period for which Health Plan (or its designee) has received appropriate payment. Group is responsible for paying Premiums, except that Members who have Cal-COBRA coverage under an EOC that is included in this Agreement are responsible for paying Premiums for Cal-COBRA coverage.

## **Due Date and Payment of Premiums**

The payment due date for each enrollment unit associated with Group will be reflected on the monthly membership invoice if applicable to Group (if not applicable, then as specified in writing by Health Plan). If Group does not pay Premiums by the first of the coverage month, the Premiums may include an additional administrative charge upon renewal.

## **New Members**

Premiums are payable for the entire month for new Members whose coverage effective date falls between the first day of the month and the fifteenth day of the month. Effective dates after the fifteenth day of the month require no payment for that month.

**Note:** Membership begins at the beginning (12:00 a.m.) of the effective date of coverage.

## **Member Termination**

Premiums are payable for Members for the entire month of termination when coverage ends.

**Note:** The membership termination date is the first day a Member is not covered (for example, if the termination date is January 1, 2010, the last minute of coverage was at 11:59 p.m. on December 31, 2009).

## **Medicare**

Except for Members for whom Medicare is secondary coverage or Members who are enrolled in both your Group's non-Medicare plan and any group's Kaiser Permanente Senior Advantage plan, Premiums are based on the assumption that Health Plan or its designee will receive Medicare payments for Medicare-covered services provided to Members eligible for Medicare benefits. Members who are "eligible for Medicare Part A" (or "eligible for Medicare Part B") are those who would qualify for Medicare Part A (or Part B) coverage if they applied for it. Members who are "entitled to Medicare Part A" (or "entitled to Medicare Part B") are those who have been granted Medicare Part A (or Part B) coverage. Each Member who is or becomes eligible for Medicare as primary coverage must comply with all of the following requirements:

- Enroll in all parts of Medicare for which he or she is eligible and continue that enrollment while a Member
- Be enrolled through Group in Kaiser Permanente Senior Advantage
- Complete and submit all documents necessary for Health Plan, or any provider from whom the Member receives services covered by Health Plan, to obtain Medicare payments for Medicare-covered services provided to the Member

If a Member does not comply with all of these requirements for any reason, including inability to enroll in a Kaiser Permanente Medicare plan because he or she does not meet the plan's eligibility requirements or the plan is not available through Group, Group must pay the applicable Premiums listed below to compensate for the lack of Medicare payments. Also, Group must accept transfer of the Member to Health Plan's non-Medicare plan if the Member is not already so enrolled.

### **Medicare as secondary coverage**

Medicare is the primary coverage except when federal law requires that Group's health care coverage be primary and Medicare coverage be secondary. Members entitled to Medicare when Medicare is secondary by law, are subject to the same Premiums and receive the same benefits as Members who are under age 65 not eligible for Medicare. In addition, any such Members for whom Medicare is secondary and who meet the Kaiser Permanente Senior Advantage eligibility requirements, may also enroll in the Kaiser Permanente Senior Advantage plan applicable when Medicare is secondary under this *Agreement*. These Members receive the benefits and coverage described in both the non-Medicare *Evidence of Coverage* and the Senior Advantage *Evidence of Coverage* applicable when Medicare is secondary.

## **Subscriber Contributions for Medicare Part D Coverage**

This "Subscriber Contributions for Medicare Part D Coverage" section applies only to Group's Kaiser Permanente Senior Advantage coverage that includes Medicare Part D prescription drug coverage. Group's Senior Advantage Premiums include the Medicare Part D premium. Group may determine how much it will require Subscribers to contribute toward the Medicare Part D premium for each Senior Advantage Member in the Subscriber's Family, subject to the following restrictions:

- If Group requires different contribution amounts for different classes of Senior Advantage Members for the Medicare Part D premium, then Group agrees to the following:
  - ◆ any such differences in classes of Members are reasonable and based on objective business criteria, such as years of service, business location, and job category, and are not based on eligibility for the Medicare Part D Low Income Subsidy (the subsidies described in 42 C.F.R. Section 423 Subpart P, which are offered by the Medicare program to certain low-income Medicare beneficiaries enrolled in Medicare Part D, and which reduce the Medicare beneficiaries' Medicare Part D premiums and/or Medicare Part D cost-sharing amounts)
  - ◆ Group will not require different Subscriber contributions toward the Medicare Part D premium for Members within the same class
- Group will not require Subscribers to pay a contribution for prescription drug coverage for a Senior Advantage Member that exceeds the Premium for prescription drug coverage (including the Medicare Part D premium)
- Health Plan will credit Group with any Low Income Subsidy amounts that Health Plan receives from CMS for Group's Members, and Health Plan will identify those Members for Group as required by CMS. For those Members, Group will first credit the Low Income Subsidy amount toward the Subscriber's contribution for that Member's Senior Advantage Premium for the same month, and will then apply any remaining portion of the Member's Low Income Subsidy toward the portion of the Senior Advantage Premium that Group pays on behalf of that Member for that month. If Group is unable to reduce the Subscriber's contribution before the Subscriber makes the contribution, Group shall, consistent with CMS guidance, refund the Low Income Subsidy amount to the Subscriber (up to the amount of the Subscriber Premium contribution for the Member for that month) within 45 days after the date Health Plan receives the Low Income Subsidy amount from CMS. Health Plan reserves the right to periodically require Group to certify that Group is either reducing Subscribers' monthly Premium contributions or refunding the Low Income Subsidy amounts to Subscribers in accord with CMS guidance
- For any Members who are eligible for the Low Income Subsidy, if the amount of that Low Income Subsidy is less than the Member's contribution for the Medicare Part D premium, then Group should inform the Member of the financial consequences of the Member's enrolling in the Member's current coverage, as compared to enrolling in another Medicare Part D plan with a monthly premium equal to or less than the Low Income Subsidy amount

**Late Enrollment Penalty.** If any Members are subject to the Medicare Part D late enrollment penalty, Premiums for those Members will increase to include the amount of the penalty.

## **Monthly Premiums**

### **Calculating the Family's Premium**

To calculate the monthly Premium that applies to a Family (a Subscriber and all of his or her Dependents):

1. Determine the coverages (*EOCs* and contract options) that apply to each Member in the Family (for example, Traditional Plan and ancillary coverages)
2. Determine the family role type and Medicare status of each Member (for family role types, please see the "Definitions" section of the *EOC* for the definition of Subscriber, Dependent, and Spouse)
3. Identify the Premium for each Member for each *EOC* and contract option in the Premium tables below based on the family role type of each Member
4. Add the Premium amounts for each Member together to arrive at the total Premium required for the Family

This *Agreement* covers the Health Plan coverage identified below with an *EOC* #. This *Agreement* does not cover the non-Health Plan coverages identified below with a "Contract Option ID," and the carrier(s) for the applicable coverage will send

its agreement to Group under separate cover. However, Group shall submit payment for all the coverages listed below to Health Plan (which is the billing administrator for the non-Health Plan coverages).

**Kaiser Permanente Senior Advantage (HMO) with Part D — EOC # 1**

*Senior Advantage*

Family role type	Medicare Parts A & B	Medicare Part B only
Subscriber	\$401.72	\$707.72
1st Dependent	\$401.72	\$707.72
2nd Dependent	\$401.72	\$707.72
Each additional Dependent	\$401.72	\$707.72

**Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage — EOC # 2**

*Working Aged*

For Members enrolled in Senior Advantage when federal law requires that Group's health care plan be primary and Medicare coverage be secondary, the Premiums are:

Family role type	Premiums
Subscriber	\$571.48
1st Dependent	\$571.49
2nd Dependent	\$474.33

**American Specialty Health Plans Chiropractic Plan — EOC # 3**

*HMO Chiro*

Family role type	Premiums
Subscriber	\$1.72
1st Dependent	\$1.73
2nd Dependent	\$1.43

**Kaiser Permanente Traditional Plan — EOC # 5**

*Traditional Plan*

<b>Members under age 65 (or 65 and over if Medicare is secondary)</b>	
Family role type	Premiums
Subscriber	\$571.48
1st Dependent	\$571.49
2nd Dependent	\$474.33
Each additional Dependent	\$0.00

<b>Members age 65 and over whose Medicare eligibility is unknown or who are eligible for or entitled to Medicare Part B only</b>	
Family role type	Premiums
Subscriber	\$1,365.98
1st Dependent	\$1,365.98
2nd Dependent	\$1,365.98

Each additional Dependent	\$1,365.98
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<b>Members age 65 and over who are eligible for or entitled to Medicare Part A</b>	
Family role type	Premiums
Subscriber	\$955.33
1st Dependent	\$955.33
2nd Dependent	\$955.33
Each additional Dependent	\$955.33

<b>Members enrolled in another carrier's Medicare Risk product</b>	
Family role type	Premiums
Subscriber	\$1,365.98
1st Dependent	\$1,365.98
2nd Dependent	\$1,365.98
Each additional Dependent	\$1,365.98

**Note:** "Eligible" for Medicare means that a person would have Medicare coverage if they purchased it through Social Security. "Entitled" to a part of Medicare means that you have the coverage. Medicare Part A provides inpatient coverage and Part B provides outpatient coverage.

### **Kaiser Permanente Senior Advantage (HMO) — Contract Option ID 6**

#### *Dental Risk*

Family role type	Premiums
Subscriber	\$17.00
1st Dependent	\$0.00
2nd Dependent	\$0.00

# Agreement Signature Page

## Acceptance of Agreement

Group acknowledges acceptance of this *Agreement* by signing the Signature Page and returning it to Health Plan. If Group does not return it to Health Plan, Group will be deemed as having accepted this *Agreement* if Group pays Health Plan any amount toward Premiums.

Group may **not** change this *Agreement* by adding or deleting words, and any such addition or deletion is void. Health Plan might not respond to any changes or comments submitted on or with this Signature Page. Group may not construe Health Plan's lack of response to any submitted changes or comments to imply acceptance. If Group wishes to change anything in this *Agreement*, Group must contact its Health Plan account manager. Health Plan will issue a new *Agreement* or amendment if Health Plan and Group agree on any changes.

## Binding Arbitration

As more fully set forth in the arbitration provision in the applicable *Evidence of Coverage*, disputes between Members, their heirs, relatives, or associated parties (on the one hand) and Health Plan, its health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising out of or related to this *Agreement*, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this *Agreement*, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. Members enrolled under this *Agreement* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the applicable *Evidence of Coverage* 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 appeals procedure as applicable to Kaiser Permanente Senior Advantage and Medicare Cost Members
- If the Member's Group must comply with the Employee Retirement Income Security Act (ERISA) requirements, the claim is a benefit-related request that constitutes a "benefit claim" in section 502(a)(1)(B) of ERISA. Note: Benefit claims under this Section of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor regulation prohibiting mandatory binding arbitration of this category of claim (29 CFR 2560.503-1(c)(4)) is modified, amended, repealed, superseded, or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without further notice

## Signatures

EL DORADO COUNTY

Kaiser Foundation Health Plan, Inc.  
Northern California Region



\_\_\_\_\_  
Authorized Group officer signature

Jerry Fleming  
Authorized officer  
Senior Vice President and Health Plan Manager

NORMA SANTIAGO, CHAIRMAN

\_\_\_\_\_  
Please print your name and title  
BOARD OF SUPERVISORS

Executed in San Diego, CA effective 7/1/10  
Date: 5/11/10

\_\_\_\_\_  
Date signed

Please sign and mail us this copy of the *Agreement* Signature Page in the enclosed business-reply envelope to our California Service Center at P.O. Box 23448, San Diego, CA 92193-3448.

ATTEST: Suzanne Allen de Sanchez  
Clerk of the Board of Supervisors


EL DORADO COUNTY  
Purchaser ID: 34936  
Contract: 1 Version: 48

By \_\_\_\_\_  
Deputy

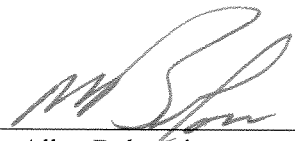
**Administrator:** The County Officer or employee with responsibility for administering this Agreement is Janet Parnell, Principal Risk Management Analyst, Human Resources, Risk Management Division, or successor.

**Entire Agreement:** This document and the documents referred to herein or exhibits hereto are the entire Agreement between the parties and they incorporate or supersede all prior written or oral Agreements or understandings.

**Requesting Contract Administrator Concurrence:**

By:  Dated: 6-17-2010  
Janet Parnell  
Principal Risk Management Analyst  
Human Resources Department, Risk Management Division

**Requesting Department Head Concurrence:**

By:  Dated: 6/18/10  
Allyn Bulzomi  
Director  
Human Resources Department

## Information for Groups Subject to ERISA

Under the Employee Retirement Income Security Act of 1974, as amended, (ERISA), the plan administrator of an ERISA-covered employee welfare benefit plan (EWBP) is responsible, among other things, for development and distribution of a *Summary Plan Description (SPD)* to plan participants. The plan administrator is often a designee of the employer or union plan sponsor. With respect to its fully-insured EWBP accounts, Kaiser Foundation Health Plan, Inc. (Health Plan) underwrites the fully-insured product through which the employer or union group health plan sponsor offers health care coverage to its plan participants. Accordingly, Health Plan is neither the "ERISA plan" nor the "plan administrator" with respect to its fully-insured group health plan accounts.

### Disclosures Required by ERISA

The plan administrator of an ERISA-covered EWBP may satisfy certain ERISA disclosure obligations by incorporating the Health Plan *Evidence of Coverage (EOC)* into its *SPD*. However, the *EOC* by itself does not satisfy the disclosure requirements under ERISA for a compliant *SPD*. Moreover, if a required disclosure is not in the *EOC*, or if the plan administrator chooses to not incorporate the *EOC* in the *SPD*, the plan administrator must provide the disclosure in the *SPD*. In addition, if there are discrepancies between the description of covered group health plan benefits appearing in the *SPD* and those reflected in the *EOC*, the benefit description appearing in the *EOC* will control.

This overview of ERISA disclosure requirements is intended to help plan administrators ensure that their *SPD* accurately reflects the terms of their fully-insured group health care coverages, as required under ERISA. However, it is the plan administrator's responsibility to verify that the EWBP's *SPD* satisfies all ERISA disclosure requirements.

SPD Disclosure	EOC Disclosure
<p>Description of coverage, including:</p> <ul style="list-style-type: none"> <li>• Cost sharing</li> <li>• Exclusions and limitations</li> <li>• Prior authorization requirements</li> <li>• Provider network</li> <li>• Claims procedure</li> </ul>	<p>Under ERISA, an <i>SPD</i> may provide only a general description of plan benefits as long as the <i>SPD</i> references a detailed schedule of benefits and incorporates it by reference. That detailed schedule of benefits can be the <i>EOC</i> that Health Plan provides to your Group, which offers a clear description of the scope of benefits covered under the plan and the rules for obtaining those benefits. If the plan administrator chooses to incorporate the <i>EOC</i> by reference into the <i>SPD</i>, it may satisfy the applicable ERISA coverage disclosure requirements by including the following language <i>without changes</i> as the introduction to the benefit chart in the <i>SPD</i>:</p> <ul style="list-style-type: none"> <li>◆ This benefit chart provides summary information only. It does not fully describe your benefit coverage. For details on your benefit coverage, please refer to your Kaiser Foundation Health Plan, Inc. (Health Plan) Evidence of Coverage. The Evidence of Coverage is the binding document between Health Plan and its members.</li> <li>◆ As a condition of coverage, a Health Plan physician must determine that any requested services and supplies are medically necessary to prevent, diagnose, or treat a medical condition. Generally, requested services and supplies must be provided, prescribed, authorized, or directed by a Health Plan provider. Except as otherwise noted in the Evidence of Coverage, you must receive the requested services and supplies from a Health Plan-designated provider inside your Health Plan Service Area except as specifically noted in the Evidence of Coverage,</li> <li>◆ For details on the benefit and claims review and adjudication procedures, please refer to the Evidence of Coverage.</li> </ul>
<p>Newborns' and Mothers' Health Protection Act (Newborn Act)</p>	<p>Health Plan provides coverage for hospital lengths of stay following childbirth for mothers and newborns in accordance with the Newborn Act. A disclosure of hospital length of stay requirements is provided in the "Hospital Inpatient Care" section of the <i>EOC</i>. Effective January 1, 2010, we have added a Newborn Act notice in the "Miscellaneous Provisions" section of the <i>EOC</i> to assist the plan administrator in complying with ERISA.</p>



SPD Disclosure	EOC Disclosure
Women's Health and Cancer Rights Act (WHCRA)	Health Plan provides coverage for mastectomy and reconstructive surgery and related services as required by WHCRA. A disclosure of coverage for reconstructive surgery is provided in the "Reconstructive Surgery" section of the <i>EOC</i> . A disclosure of coverage for breast prosthesis and lymphedema wraps is provided in the "Prosthetic and Orthotic Devices" sections of the <i>EOC</i> . Effective January 1, 2010, we have added a WHCRA notice in the "Miscellaneous Provisions" section of the <i>EOC</i> to assist the plan administrator in complying with ERISA.
Eligibility	The <i>EOC</i> does not include detailed information about your Group's eligibility requirements. The plan administrator must furnish such eligibility information to plan participants in the EWBP <i>SPD</i> . Note: Health Plan does not impose preexisting condition exclusions or waiting periods, or require that employees be actively at work at the time of enrollment. Therefore, the <i>EOC</i> does not contain a notice of preexisting condition exclusions, waiting periods, or any actively-at-work provision.
ERISA rights	The <i>EOC</i> does not contain a statement of ERISA rights. The plan administrator must furnish this information to plan participants in the <i>SPD</i> .
Special enrollment, including: <ul style="list-style-type: none"> <li>• Special enrollment due to new dependents</li> <li>• Special enrollment due to loss of other coverage</li> <li>• Special enrollment due to court or administrative order</li> </ul>	The <i>EOC</i> includes a disclosure about special enrollment rights. Please refer to "Special enrollment" under "When You Can Enroll and When Coverage Begins" in the "Premiums, Eligibility and Enrollment" section. The plan administrator is required to document that the plan participants have been informed of these rights. Note: The <i>EOC</i> does not include a description of the procedures governing qualified medical child support order (QMCSO) determinations or a statement indicating that [plan participants] [beneficiaries] can obtain, without charge, a copy of such procedures from the plan administrator. The plan administrator should include this information in the <i>SPD</i> .
HIPAA Certificate of Creditable Coverage	In general, Health Plan furnishes plan [participants] [beneficiaries] with HIPAA certificates of creditable coverage upon termination of coverage. The <i>EOC</i> disclosure about these certificates is under "HIPAA Certificates of Creditable Coverage" included in the "Termination of Membership" section.
COBRA	The <i>EOC</i> discloses that continuation health care coverage under federal COBRA or under state continuation coverage laws may be available following termination of group health coverage. However, Health Plan does not offer COBRA/continuation coverage administrative services to EWBPs except for certain limited functions upon specific group request and agreement to terms. If your EWBP offers federal continuation coverage, your plan administrator is responsible for providing all notices related to continuation coverage, eligibility, and participation.
Information about the EWBP and how it is administered, such as: <ul style="list-style-type: none"> <li>• Name of the plan</li> <li>• Name and address of the entity maintaining the plan</li> <li>• Employer identification number, plan number, type of plan, and how it is administered</li> <li>• The plan administrator's authority to terminate the plan or amend benefits, circumstances that may trigger ineligibility, denial, or reduction of benefits, and rights upon termination of plan or amendment of benefits</li> </ul>	Health Plan does not collect this information from groups and cannot include it in the <i>EOC</i> . The plan administrator must include this information in the <i>SPD</i> .

**Additional information about ERISA claims**

With respect to ERISA covered EWBP, plan participants' requests for payment or services may be subject to both ERISA requirements and California law.

Required Disclosure	EOC Disclosure
Claims procedures	Effective January 1, 2010, the disclosure concerning post-service claims for emergency care, post-stabilization care, and out-of-area urgent care from non-Plan providers appears under "Payment and Reimbursement" in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section of the EOC. The disclosure concerning pre-service claims, concurrent care claims, and post-service claims other than claims for emergency, post-stabilization, or out-of-area urgent care from non-Plan providers appears under "Grievances" in the "Dispute Resolution" section of the EOC. Note: the "Binding Arbitration" section specifies that binding arbitration is not required for certain benefit-related claims subject to ERISA.



Kaiser Foundation Health Plan, Inc.  
Northern California Region

*A nonprofit corporation*

## **Kaiser Permanente Traditional Plan Evidence of Coverage for EL DORADO COUNTY**

Purchaser ID: 34936 Contract: 1 Version: 48 EOC Number: 5



*July 1, 2010, through June 30, 2011*

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

**Help in your language**

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

**Ayuda en su propio idioma**

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

**語言翻譯協助**

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

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## Benefit Highlights

### Annual Out-of-Pocket Maximum for Certain Services

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

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

<b>Deductible or Lifetime Maximum</b>	None
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### Professional Services (Plan Provider office visits) You Pay

Routine preventive care:	
Physical exams .....	\$15 per visit
Well-child visits (through age 23 months) .....	\$5 per visit
Family planning visits .....	\$15 per visit
Scheduled prenatal care visits and first postpartum visit .....	\$5 per visit
Eye exams for refraction .....	\$15 per visit
Hearing tests .....	\$15 per visit
Flexible sigmoidoscopies .....	\$15 per visit
Primary and specialty care visits .....	\$15 per visit
Urgent care visits.....	\$15 per visit
Physical, occupational, and speech therapy.....	\$15 per visit

### Outpatient Services You Pay

Outpatient surgery and certain other outpatient procedures .....	\$15 per procedure
Allergy injection visits .....	\$3 per visit
Allergy testing visits.....	\$15 per visit
Most vaccines (immunizations).....	No charge
X-rays and lab tests .....	No charge
Health education:	
Individual visits .....	\$15 per visit
Group educational programs .....	No charge

### Hospitalization Services You Pay

Room and board, surgery, anesthesia, X-rays, lab tests, and drugs .....	No charge
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### Emergency Health Coverage You Pay

Emergency Department visits .....	\$15 per visit
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Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient (see "Hospitalization Services" for inpatient Cost Sharing).

### Ambulance Services You Pay

Ambulance Services .....	No charge
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### Prescription Drug Coverage You Pay

Most covered outpatient items in accord with our drug formulary guidelines from Plan Pharmacies or from our mail-order service .....	\$10 for up to a 100-day supply
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### Durable Medical Equipment You Pay

Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines .....	No charge
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### Mental Health Services You Pay

Inpatient psychiatric hospitalization and intensive psychiatric treatment programs.....	No charge
Outpatient individual and group visits .....	\$15 per individual visit \$7 per group visit

<b>Chemical Dependency Services</b>	<b>You Pay</b>
Inpatient detoxification.....	No charge
Outpatient individual visits .....	\$15 per visit
Outpatient group visits .....	\$5 per visit
<b>Home Health Services</b>	<b>You Pay</b>
Home health care (up to 100 visits per calendar year) .....	No charge
<b>Other</b>	<b>You Pay</b>
Eyewear purchased from Plan Optical Sales Offices every 24 months.....	Amount in excess of \$175 Allowance
Hearing aid(s) every 36 months .....	Amount in excess of \$2,500 Allowance per aid
Skilled Nursing Facility care (up to 100 days per benefit period).....	No charge
Hospice care .....	No charge

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



## Introduction

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

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

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

### Term of this Evidence of Coverage

This *Evidence of Coverage* is for the period July 1, 2010, through June 30, 2011, unless amended. Your Group can tell you whether this *Evidence of Coverage* is still in effect and give you a current one if this *Evidence of Coverage* has expired or been amended.

### About Kaiser Permanente

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

We provide covered Services to Members using Plan Providers located in our Service Area, which is described in the "Definitions" section. You must receive all covered care from Plan Providers inside our Service

Area, except as described in the sections listed below for the following Services:

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

## Definitions

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

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

**Charges:** Charges means the following:

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

**Clinically Stable:** You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

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

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

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

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

**Dependent:** A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

**Emergency Care:**

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

**Emergency Medical Condition:** Any of the following:

- A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs
- Active labor when there isn't enough time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety
- A mental disorder that manifests itself by acute symptoms of sufficient severity such that either you are an immediate danger to yourself or others, or you are not immediately able to provide for, or use, food, shelter, or clothing, due to the mental disorder

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Plan 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 Call Center.

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

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

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

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

**Post-Stabilization Care:** Medically Necessary Services related to your Emergency Medical Condition that you

receive after your treating physician determines that this condition is Clinically Stable.

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

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

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

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

- Amador: 95640, 95669
- El Dorado: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762
- Fresno: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–30, 93741, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–79, 93784, 93786, 93790–94, 93844, 93888
- Kings: 93230, 93232, 93242, 93631, 93656
- Madera: 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720
- Mariposa: 93601, 93623, 93653
- Napa: 94503, 94508, 94515, 94558–59, 94562, 94567\*, 94573–74, 94576, 94581, 94589–90, 94599, 95476
- Placer: 95602–04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95692, 95703, 95722, 95736, 95746–47, 95765



- Santa Clara: 94022–24, 94035, 94039–43, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–36, 95138–41, 95148, 95150–61, 95164, 95170, 95172–73, 95190–94, 95196
- Sonoma: 94515, 94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, 95492
- Sutter: 95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 95836–37
- Tulare: 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
- Yolo: 95605, 95607, 95612, 95616–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99
- Yuba: 95692, 95903, 95961

\*Exception: Knoxville is not in our Service Area.

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

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

**Services:** Health care services or items.

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

**Spouse:** Your legal husband or wife. For the purposes of this *Evidence of Coverage*, the term "Spouse" includes your registered domestic partner who meets all of the requirements of Section 297 of the California Family

Code, or your domestic partner in accord with your Group's requirements, if any.

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

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

## Premiums, Eligibility, and Enrollment

### Premiums

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

### Who Is Eligible

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

### **Group eligibility requirements**

You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of its eligibility requirements, such as the minimum number of hours that employees must work. Please note that your Group might *not* allow enrollment to some persons who meet the requirements described under "Service Area eligibility requirements" and "Additional eligibility requirements" below.

### **Service Area eligibility requirements**

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

Subscribers must live or work inside our Service Area at the time they enroll. If after enrollment the Subscriber no longer lives or works inside our Service Area, the Subscriber can continue membership unless he or she

lives inside or moves to the service area of another Region and does not work inside our Service Area.

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

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

- **Regions outside California.** You may be able to enroll in the service area of another Region if there is an agreement between your Group and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same. For the purposes of this eligibility rule, the Regions outside California may change on January 1 of each year and are currently the District of Columbia and parts of Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington
- **Southern California Region's service area.** Your Group may have an arrangement with us that permits membership in the Southern California Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *Evidence of Coverage*. All terms and conditions in your application for enrollment in the Northern California Region, including the Arbitration Agreement, will continue to apply if the Subscriber does not submit a new enrollment form

For more information about the service areas of the other Regions, please call our Member Service Call Center.

### Additional eligibility requirements

You may be eligible to enroll and continue enrollment as a Subscriber if you are:

- An employee of your Group
- A proprietor or partner of your Group
- Otherwise entitled to coverage under a trust agreement, retirement benefit program, or employment contract (unless the Internal Revenue Service considers you self-employed)

If you are a Subscriber and if your Group allows enrollment of Dependents, the following persons may be eligible to enroll as your Dependents:

- Your Spouse. For the purposes of this *Evidence of Coverage*, the term "Spouse" includes your registered

domestic partner who meets all the requirements of Section 297 of the California Family Code, or your domestic partner in accord with your Group's requirements, if any

- Your or your Spouse's unmarried children (including adopted children or children placed with you for adoption) who are under age 19, or under age 23 if a student as defined by your Group
- Other unmarried dependent persons (but not including foster children) who meet all of the following requirements:
  - ♦ they are under age 19, or under age 23 if a student as defined by your Group
  - ♦ they receive all of their support and maintenance from you or your Spouse
  - ♦ they permanently reside with the Subscriber
  - ♦ you or your Spouse is the court-appointed guardian (or was when the person reached age 18) or the person's parent is an enrolled Dependent under your family coverage
- Dependents who meet the Dependent eligibility requirements, except for the age limit, may be eligible as a disabled dependent if they meet all the following requirements:
  - ♦ they are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred prior to reaching the age limit for Dependents
  - ♦ they receive 50 percent or more of their support and maintenance from you or your Spouse
  - ♦ you give us proof of their incapacity and dependency within 60 days after we request it (see "Disabled dependent certification" below in this "Additional eligibility requirements" section)

**Disabled dependent certification.** A dependent who meets the Dependent eligibility requirements except for the age limit may be eligible as a disabled dependent as described above under "Additional eligibility requirements" in this "Premiums, Eligibility, and Enrollment" section. You must provide us documentation of your dependent's incapacity and dependency as follows:

- If your Dependent is a Member, we will send you a notice of his or her membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. Your Dependent's membership will terminate as described in our notice unless you provide us documentation of his or her incapacity and dependency within 60 days of receipt of our notice and we determine that he or she is eligible as a disabled dependent. If you provide us this documentation in the specified time period and



we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that your Dependent does not meet the eligibility requirements as a disabled dependent, we will notify you that he or she is not eligible and let you know the membership termination date. If we determine that your Dependent is eligible as a disabled dependent, there will be no lapse in coverage. Also, two years after the date that your Dependent reached the age limit, you must provide us documentation of his or her incapacity and dependency annually within 60 days after we request it so that we can determine if he or she continues to be eligible as a disabled dependent

- If your dependent is not a Member and you are requesting enrollment, you must provide us documentation of his or her incapacity and dependency within 60 days after we request it so that we can determine if he or she is eligible to enroll as a disabled dependent. If we determine that your dependent is eligible as a disabled dependent, you must provide us documentation of his or her incapacity and dependency annually within 60 days after we request it so that we can determine if he or she continues to be eligible as a disabled dependent

**Student eligibility.** In order for a Dependent age 19 and over to be eligible for membership as a student, as described above under "Additional eligibility requirements" in this "Who Is Eligible" section, one of the following must occur:

- If your Group has an agreement with us for the Group to certify student eligibility, then the Subscriber must follow the Group's procedures for certifying student eligibility and the Group must then certify the student's eligibility (your Group can tell you whether it has an agreement with us to certify student eligibility and, if it does, what its procedures are)
- If your Group does not have an agreement with us to certify student eligibility, then the Subscriber must complete and send us our student certification form affirming that the Dependent is a student as defined by your Group. You can get a copy of the form by visiting our Web site at [kp.org](http://kp.org) or by calling our Member Service Call Center

Breaks in the school calendar will not disqualify a Dependent from being classified as a student for eligibility purposes. Students taking a medically necessary leave of absence are classified as students for eligibility purposes for up to 12 months, though they will remain eligible for membership only if they continue to meet all other eligibility requirements. Dependent Members age 19 and over who are eligible for membership because they are students and who take a

medically necessary leave of absence will remain covered until the earliest of the following dates:

- The date the leave ends
- The date that is 12 months after the leave began
- The date that coverage ends for a reason other than the Member's student status (for example, if the student reaches age 23)

Students who return to school after their leave ends may be eligible for membership if they meet all eligibility requirements. Documentation of the medical necessity for the leave must be submitted at least 30 days before the leave begins, if the absence and the medical reason for the absence are foreseeable. If the absence and the medical reason for the absence are not foreseeable, then documentation of the medical necessity for the leave must be submitted within 30 days after the leave begins.

### **Persons barred from enrolling**

You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

### **Members with Medicare and retirees**

This plan is not intended for most Medicare beneficiaries and some Groups do not offer coverage to retirees. If, during the term of this *Evidence of Coverage*, you are or become eligible for Medicare (please see "Medicare" in the "Definitions" section for the meaning of "eligible for Medicare") or you retire, please ask your Group about your membership options as follows:

- If a Subscriber who is entitled to Medicare Part B retires and the Subscriber's Group has a Kaiser Permanente Senior Advantage plan for retirees, the Subscriber should enroll in the plan if eligible
- If the Subscriber retires and your Group does not offer coverage to retirees, you may be eligible to continue membership as described in the "Continuation of Membership" section
- If federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary, your coverage under this *Evidence of Coverage* will be the same as it would be if you had not become eligible for Medicare. However, you may also be eligible to enroll in Kaiser Permanente Senior Advantage through your Group if you are entitled to Medicare Part B
- If you are or become eligible for Medicare and are in a class of beneficiaries for which your Group's health care coverage is secondary to Medicare, you should consider enrollment in Kaiser Permanente Senior Advantage through your Group if you are eligible

- If none of the above applies to you and you are eligible for Medicare or you retire, please ask your Group about your membership options

**When Medicare is primary.** Your Group's Premiums may increase if you are or become eligible for Medicare Part A or B as primary coverage, and you are not enrolled through your Group in Kaiser Permanente Senior Advantage for any reason (even if you are not eligible to enroll or the plan is not available to you). If your Group fails to pay the entire Premiums required for your Family, your membership will be terminated in accord with "Partial payment of Premiums for a Family" under "Termination for Nonpayment" in the "Termination of Membership" section.

**When Medicare is secondary.** Medicare is the primary coverage except when federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary. Members who are entitled to Medicare when Medicare is secondary by law are subject to the same Premiums and receive the same benefits as Members who are under age 65 and not entitled to Medicare. In addition, any such Member for whom Medicare is secondary by law and who meets the eligibility requirements for the Kaiser Permanente Senior Advantage plan applicable when Medicare is secondary may also enroll in that plan if it is available. These Members receive the benefits and coverage described in this *Evidence of Coverage* and the Kaiser Permanente Senior Advantage evidence of coverage applicable when Medicare is secondary.

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

**Capacity limit.** You may be ineligible to enroll in Kaiser Permanente Senior Advantage if that plan has reached a

capacity limit that the Centers for Medicare & Medicaid Services has approved. This limitation does not apply if you are currently a Health Plan Member in the Northern California or Southern California Region who is eligible for Medicare (for example, when you turn age 65).

## **When You Can Enroll and When Coverage Begins**

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

### **New employees**

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Health Plan–approved enrollment application to your Group within 31 days.

**Effective date of coverage.** The effective date of coverage for new employees and their eligible family Dependents is determined by your Group.

### **Adding new Dependents to an existing account**

To enroll a Dependent who first becomes eligible to enroll after you became a Subscriber (such as a new Spouse, a newborn child, or a newly adopted child), you must submit a Health Plan–approved change of enrollment form to your Group within 31 days after the Dependent first becomes eligible.

**Effective date of coverage.** Other than a newborn or a newly adopted child (including a child placed with you for adoption), the effective date of coverage for newly acquired Dependents is determined by your Group. For a newborn or a newly adopted child, the effective date of coverage is as follows:

- A newborn child is covered from the moment of birth if the Subscriber enrolls the child within 31 days after birth. Any Premiums required for the newborn will be effective the first of the month following birth
- If the newborn child is not enrolled within 31 days, the newborn is covered only for 31 days (including the date of birth)

- The membership of a newly adopted child (including a child placed with you for adoption) will begin on the date when the adopting parent gains the legal right to control the child's health care if the Subscriber enrolls the child within 31 days of that date

### Open enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan–approved enrollment application to your Group during your Group's open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the effective date of coverage.

### Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

- You become eligible as described in this "Special enrollment" section
- You did not enroll when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. The effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application from the Subscriber

**Special enrollment due to new Dependents.** You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, within 30 days after marriage, establishment of domestic partnership, birth, adoption, or placement for adoption by submitting to your Group a Health Plan–approved enrollment application.

The effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber. Enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, adoption, or placement for adoption.

**Special enrollment due to loss of other coverage.** You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, if all of the following are true:

- The Subscriber or at least one of the Dependents had other coverage when he or she previously declined Health Plan coverage

- The loss of the other coverage is due to one of the following:
  - ◆ exhaustion of COBRA coverage
  - ◆ termination of employer contributions for non-COBRA coverage
  - ◆ loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due legal separation or divorce, reaching the age limit for dependent children, or the subscriber's death, termination of employment, or reduction in hours of employment
  - ◆ loss of eligibility (but not termination for cause) for Medicaid coverage (known as Medi-Cal in California), Children's Health Insurance Program coverage (known as the Healthy Families Program in California), or Access for Infants and Mothers Program coverage
  - ◆ reaching a lifetime maximum on all benefits

Note: If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, only one of you must meet the requirements stated above.

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 30 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for Medicaid, Children's Health Insurance Program, or Access for Infants and Mothers Program coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

**Special enrollment due to court or administrative order.** Within 31 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved enrollment or change of enrollment application.

Your Group will determine the effective date of an enrollment resulting from a court or administrative order, except that the effective date cannot be earlier than the date of the order and cannot be later than the first day of the month following the date of the order.



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

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

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

## How to Obtain Services

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

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

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

### Routine Care

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

### Urgent Care

When you are sick or injured, you may have an Urgent Care need. An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice nurse

## Our Advice Nurses

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. Whether you are calling for advice or to make an appointment, you can speak to an advice nurse. They can often answer questions about a minor concern, tell you what to do if a Plan Medical Office is closed, or advise you about what to do next, including making a same-day Urgent Care appointment for you if it's medically appropriate. To reach an advice nurse, please refer to *Your Guidebook* for the telephone numbers.

## Your Personal Plan Physician

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

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

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



## Getting a Referral

### Referrals to Plan Providers

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

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

### Medical Group authorization procedure for certain referrals

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

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

will authorize the item if he or she determines that it is Medically Necessary. For more information about our soft goods formulary, please refer to "Ostomy and Urological Supplies" in the "Benefits and Cost Sharing" section

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

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

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

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

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

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

### Completion of Services from Non-Plan Providers

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

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

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

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

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

- Your Health Plan coverage is in effect on the date you receive the Service
- For new Members, your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective



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

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

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

## Second Opinions

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

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

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

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

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

## Contracts with Plan Providers

### **How Plan Providers are paid**

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

### **Financial liability**

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

### **Termination of a Plan Provider's contract**

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

**Provider groups and hospitals.** If you are assigned to a provider group or hospital whose contract with us terminates, or if you live within 15 miles of a hospital whose contract with us terminates, we will give you

written notice at least 60 days before the termination (or as soon as reasonably possible).

## **Visiting Other Regions**

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

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

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

## **Your ID Card**

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

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

## **Getting Assistance**

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your personal Plan Physician or with other Plan Providers

who are treating you. They are committed to your satisfaction and want to help you with your questions.

## **Member Services**

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

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

## **Interpreter services**

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

## **Plan Facilities**

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

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Care is available from Plan Hospital Emergency Departments as described in *Your Guidebook* (please refer to *Your Guidebook* for Emergency Department locations in your area)

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

### **Plan Hospitals and Plan Medical Offices**

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

#### **Alameda**

- Medical Offices: 2417 Central Ave.

#### **Antioch**

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

#### **Campbell**

- Medical Offices: 220 E. Hacienda Ave.

#### **Clovis**

- Medical Offices: 2071 Herndon Ave.

#### **Daly City**

- Medical Offices: 395 Hickey Blvd.

#### **Davis**

- Medical Offices: 1955 Cowell Blvd.

#### **Elk Grove**

- Medical Offices: 9201 Big Horn Blvd.

#### **Fairfield**

- Medical Offices: 1550 Gateway Blvd.

#### **Folsom**

- Medical Offices: 2155 Iron Point Rd.

#### **Fremont**

- Hospital and Medical Offices: 39400 Paseo Padre Pkwy.

#### **Fresno**

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

#### **Gilroy**

- Medical Offices: 7520 Arroyo Circle

#### **Hayward**

- Hospital and Medical Offices: 27400 Hesperian Blvd.

#### **Lincoln**

- Medical Offices: 1900 Dresden Dr.

#### **Livermore**

- Medical Offices: 3000 Las Positas Rd.

#### **Manteca**

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

#### **Martinez**

- Medical Offices: 200 Muir Rd.

#### **Milpitas**

- Medical Offices: 770 E. Calaveras Blvd.

#### **Modesto**

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

#### **Mountain View**

- Medical Offices: 555 Castro St.

#### **Napa**

- Medical Offices: 3285 Claremont Way

#### **Novato**

- Medical Offices: 97 San Marin Dr.

#### **Oakhurst**

- Medical Offices: 40595 Westlake Dr.

#### **Oakland**

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

#### **Petaluma**

- Medical Offices: 3900 Lakeville Hwy.

**Pinole**

- Medical Offices: 1301 Pinole Valley Rd.

**Pleasanton**

- Medical Offices: 7601 Stoneridge Dr.

**Rancho Cordova**

- Medical Offices: 10725 International Dr.

**Redwood City**

- Hospital and Medical Offices: 1150 Veterans Blvd.

**Richmond**

- Hospital and Medical Offices: 901 Nevin Ave.

**Rohnert Park**

- Medical Offices: 5900 State Farm Dr.

**Roseville**

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

**Sacramento**

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

**San Bruno**

- Medical Offices: 901 El Camino Real

**San Francisco**

- Hospital and Medical Offices: 2425 Geary Blvd.

**San Jose**

- Hospital and Medical Offices: 250 Hospital Pkwy.

**San Rafael**

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

**Santa Clara**

- Hospital and Medical Offices: 700 Lawrence Expwy.

**Santa Rosa**

- Hospital and Medical Offices: 401 Bicentennial Way

**Selma**

- Medical Offices: 2651 Highland Ave.

**South San Francisco**

- Hospital and Medical Offices: 1200 El Camino Real

**Stockton**

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

**Tracy**

- Medical Offices: 2185 W. Grant Line Rd.

**Turlock**

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

**Union City**

- Medical Offices: 3553 Whipple Rd.

**Vacaville**

- Hospital and Medical Offices: 1 Quality Dr.

**Vallejo**

- Hospital and Medical Offices: 975 Sereno Dr.

**Walnut Creek**

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

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

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

**Your Guidebook to Kaiser Permanente Services (Your Guidebook)**

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



updated. You can get a copy by visiting our Web site at [kp.org](http://kp.org) or by calling our Member Service Call Center.

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

This "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section explains how to obtain covered Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care from Non-Plan Providers. We do not cover the Non-Plan Provider care discussed in this section unless it meets both of the following requirements:

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

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

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

## **Prior Authorization**

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

## **Emergency Care**

If you have an Emergency Medical Condition, call 911 or go to the nearest hospital. When you have an Emergency Medical Condition, we cover Emergency Care anywhere in the world.

An Emergency Medical Condition is any of the following:

- A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs
- Active labor when there isn't enough time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety
- A mental disorder that manifests itself by acute symptoms of sufficient severity such that either you are an immediate danger to yourself or others, or you are not immediately able to provide for, or use, food, shelter, or clothing, due to the mental disorder

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

## **Post-Stabilization Care**

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

To request authorization to receive Post-Stabilization Care from a Non-Plan Provider, you must call us toll free at **1-800-225-8883** (TTY users call 711) or the notification telephone number on your Kaiser Permanente ID card *before* you receive the care if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible). After we are notified, we will discuss your condition with the Non-Plan Provider. If we decide that you require Post-Stabilization Care and that this care would be covered if you received it from a Plan Provider, we will authorize your care from the Non-Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. If we decide to



have a Plan Hospital, Plan Skilled Nursing Facility, or designated Non-Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered.

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

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

### **Out-of-Area Urgent Care**

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

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

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

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

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

- Emergency Care, Post-Stabilization Care, and Urgent Care from Plan Providers

### **Payment and Reimbursement**

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

#### **How to file a claim**

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

- As soon as possible, send us a completed claim form. You can get a claim form by visiting our Web site at **kp.org** or by calling our Member Service Call Center toll free at 1-800-464-4000 or 1-800-390-3510 (TTY users call 1-800-777-1370). One of our representatives will be happy to assist you if you need help completing our claim form
- If you have paid for Services, you must include any bills and receipts from the Non-Plan Provider with your claim form
- To request that we pay a Non-Plan Provider for Services, you must include any bills from the Non-Plan Provider with your claim form. If the Non-Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If you later receive any bills from the Non-Plan Provider for covered Services (other than bills for your Cost Sharing amount), please call our Member Service Call Center toll free at 1-800-390-3510 for assistance
- The completed claim form and any bills or receipts must be mailed to the following address as soon as possible after receiving the care:  
Kaiser Foundation Health Plan, Inc.  
Claims Department  
P.O. Box 12923  
Oakland, CA 94604-2923

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

may be entitled, or original travel tickets to validate your claim.

We will respond to your claim as follows:

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

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

### **Cost Sharing**

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

## **Benefits and Cost Sharing**

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

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except where

specifically noted to the contrary in the sections listed below for the following Services:

- ♦ emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
- ♦ Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section
- You receive the Services from Plan Providers inside our Service Area, except where specifically noted to the contrary in the sections listed below for the following Services:
  - ♦ authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
  - ♦ emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
  - ♦ Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section
  - ♦ hospice care as described under "Hospice Care" in this "Benefits and Cost Sharing" section

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

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

### **Cost Sharing**

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

- If you are receiving covered inpatient hospital or Skilled Nursing Facility Services on the effective date of this *Evidence of Coverage*, you pay the Cost Sharing in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Sharing in effect on the date you receive the Services
- For items ordered in advance, you pay the Cost Sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all the information they need to fill the prescription
- Before starting or continuing a course of infertility Services, you may be required to pay initial and subsequent deposits toward your Cost Sharing for some or all of the entire course of Services, along with any past-due infertility-related Cost Sharing. Any unused portion of your deposit will be returned to you. When a deposit is not required, before you can schedule an infertility procedure, you must pay the Cost Sharing for the procedure, along with any past-due infertility-related Cost Sharing
- If you receive more than one Service from a provider, or Services from more than one provider, you may be required to pay separate Cost Sharing amounts for each Service and each provider. For example, if you receive Services from two specialists in one visit, you may have to pay the Cost Sharing for two specialist visits. Similarly, if your physician performs a procedure immediately after a consultation, you may have to pay separate Cost Sharing amounts for the consultation visit and for the procedure. If you have questions about Cost Sharing, please contact our Member Service Call Center
- In some cases, we may agree to bill you for your Cost Sharing amounts

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

### **Copayments and Coinsurance**

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

### **Annual out-of-pocket maximum**

There is a limit to the total amount of Cost Sharing you must pay under this *Evidence of Coverage* in a calendar year for all of the covered Services listed below that you receive in the same calendar year. The limit is one of the following amounts:

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

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

**Payments that count toward the maximum.** The Copayments and Coinsurance you pay for the following Services apply toward the annual out-of-pocket maximum except that Copayments and Coinsurance you pay for Services covered under "Infertility Services" in this "Benefits and Cost Sharing" section do not apply to the annual out-of-pocket maximum:

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



- Prosthetic and orthotic devices
- Skilled Nursing Facility care
- Transitional residential recovery Services and residential rehabilitation for chemical dependency

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

### Preventive Care Services

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

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

- ◆ sexually transmitted disease (STD) tests

### Outpatient Care

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

- Routine preventive care:
  - ◆ physical exams, including well-woman visits: **a \$15 Copayment per visit**
  - ◆ well-child visits for Members through age 23 months: **a \$5 Copayment per visit**
  - ◆ family planning visits for counseling, or to obtain emergency contraceptive pills, injectable contraceptives, internally implanted time-release contraceptives, or intrauterine devices (IUDs): **a \$15 Copayment per visit**
  - ◆ after confirmation of pregnancy, the normal series of regularly scheduled preventive care prenatal visits and the first postpartum visit: **a \$5 Copayment per visit**
  - ◆ eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses: **a \$15 Copayment per visit**
  - ◆ hearing tests to determine the need for hearing correction: **a \$15 Copayment per visit**
  - ◆ vaccines (immunizations) administered to you in a Plan Medical Office: **no charge**
  - ◆ flexible sigmoidoscopies: **a \$15 Copayment per visit**
- Primary and specialty care visits: **a \$15 Copayment per visit**
- Allergy injection visits: **a \$3 Copayment per visit**
- Outpatient surgery and other outpatient procedures: **a \$15 Copayment per procedure**
- Voluntary termination of pregnancy: **a \$15 Copayment per procedure**
- Physical, occupational, and speech therapy: **a \$15 Copayment per visit**
- Physical, occupational, and speech therapy provided in our organized, multidisciplinary rehabilitation day-treatment program: **a \$15 Copayment per day**
- Urgent Care visits: **a \$15 Copayment per visit**
- Emergency Department visits: **a \$15 Copayment per visit**. The Emergency Department Copayment does not apply if you are admitted directly to the hospital as an inpatient, or if you are admitted for observation and are then admitted directly to the hospital as an inpatient (for inpatient care, please refer to "Hospital Inpatient Care" in this "Benefits and Cost Sharing"

section). The Emergency Department Copayment does apply if you are admitted for observation but are not admitted as an inpatient

- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician: **no charge**
- Blood, blood products, and their administration: **no charge**
- Administered drugs (drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials) prescribed in accord with our drug formulary guidelines, if administration or observation by medical personnel is required and they are administered to you in a Plan Medical Office or during home visits: **no charge**
- Some types of outpatient visits may be available as group appointments, which we cover at a **\$7 Copayment per visit**

#### **Services not covered under this "Outpatient Care" section**

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

- Bariatric Surgery
- Chemical Dependency Services
- Dental Services for Radiation Treatment and Dental Anesthesia
- Dialysis Care
- Durable Medical Equipment for Home Use
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Infertility Services
- Mental Health Services
- Ostomy and Urological Supplies
- Outpatient Imaging, Laboratory, and Special Procedures
- Outpatient Prescription Drugs, Supplies, and Supplements
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Transplant Services
- Vision Services

#### **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 our Service Area:

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

#### **Services not covered under this "Hospital Inpatient Care" section**

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

- Bariatric Surgery
- Chemical Dependency Services
- Dental Services for Radiation Treatment and Dental Anesthesia



- Dialysis Care
- Hospice Care
- Infertility Services
- Mental Health Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Skilled Nursing Facility Care
- Transplant Services

## **Ambulance Services**

### **Emergency**

When you have an Emergency Medical Condition, we cover emergency Services of a licensed ambulance anywhere in the world at **no charge**. In accord with the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section, we cover emergency ambulance Services that are not ordered by us only if one of the following is true:

- Your treating physician determines that you must be transported to another facility when you are not Clinically Stable because the care you need is not available at the treating facility
- You are not already being treated, and you reasonably believe that your condition requires ambulance transportation

### **Nonemergency**

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

### **Ambulance Services exclusion**

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

## **Bariatric Surgery**

We cover hospital inpatient care (including room and board, imaging, laboratory, special procedures, and Plan

Physician Services) at **no charge** 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

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 the Medical Group gives you prior written authorization for travel and lodging reimbursement and if you 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

### **Services not covered under this "Bariatric Surgery" section**

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

- Office visits and other outpatient care (refer to "Outpatient Care")

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

## **Chemical Dependency Services**

### **Inpatient detoxification**

We cover hospitalization at **no charge** in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

### **Outpatient chemical dependency care**

We cover the following Services for treatment of chemical dependency:

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

You pay the following for these covered Services:

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

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

### **Transitional residential recovery Services**

We cover chemical dependency treatment in a nonmedical transitional residential recovery setting approved in writing by the Medical Group. We cover these Services at **no charge**. These settings provide counseling and support services in a structured environment.

### **Residential rehabilitation**

We cover at **no charge** care in a residential rehabilitation program approved in writing by the Medical Group.

### **Services not covered under this "Chemical Dependency Services" section**

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

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

### **Chemical dependency Services exclusion**

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

## **Dental Services for Radiation Treatment and Dental Anesthesia**

### **Dental Services for radiation treatment**

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

### **Dental anesthesia**

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

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

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

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



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

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

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

### **Dialysis Care**

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

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

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

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

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

### **Services not covered under this "Dialysis Care" section**

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

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

### **Durable Medical Equipment for Home Use**

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

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

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

### **Durable medical equipment for diabetes**

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

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

### **Outside the Service Area**

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

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

### **About our durable medical equipment formulary**

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



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

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

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

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

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

#### **Durable medical equipment for home use exclusions**

- Comfort, convenience, or luxury equipment or features
- Exercise or hygiene equipment
- Dental appliances
- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies)
- Electronic monitors of the heart or lungs except infant apnea monitors

## **Health Education**

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

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

## **Hearing Services**

We cover the following:

- Hearing tests to determine the appropriate hearing aid: **no charge**
- A **\$2,500 Allowance** for each ear toward the purchase price of a hearing aid every 36 months when prescribed by a Plan Physician or by a Plan Provider who is an audiologist. We will cover hearing aids for both ears only if both aids are required to provide significant improvement that is not obtainable with only one hearing aid. We will not provide the Allowance if we have provided an Allowance toward (or otherwise covered) a hearing aid within the previous 36 months. Also, the Allowance can only be used at the initial point of sale. If you do not use all of your Allowance at the initial point of sale, you cannot use it later
- Visits to verify that the hearing aid conforms to the prescription: **no charge**
- Visits for fitting, counseling, adjustment, cleaning, and inspection after the warranty is exhausted: **no charge**

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

#### **Services not covered under this "Hearing Services" section**

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

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



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

### **Hearing Services exclusions**

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

### **Home Health Care**

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

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

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

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

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

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

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

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

### **Home health care exclusions**

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

### **Hospice Care**

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

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

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

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

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

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

## Infertility Services

We cover the following Services related to involuntary infertility:

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

You pay the following for these Services related to involuntary infertility:

- Office visits: **a \$15 Copayment per visit**
- Outpatient surgery and other outpatient procedures: **a \$15 Copayment per procedure**
- Outpatient imaging, laboratory, and special procedures: **no charge**
- Hospital inpatient care (including room and board, imaging, laboratory, and special procedures, and Plan Physician Services): **no charge**

### **Services not covered under this "Infertility Services" section**

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

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

### **Infertility Services exclusions**

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

## Mental Health Services

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

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

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

- Severe Mental Illness means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major



depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

- A Serious Emotional Disturbance of a child under age 18 means mental disorders as identified in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:
  - ◆ as a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either (1) the child is at risk of removal from the home or has already been removed from the home, or (2) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
  - ◆ the child displays psychotic features, or risk of suicide or violence due to a mental disorder
  - ◆ the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

### **Outpatient mental health Services**

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

You pay the following for these covered Services:

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

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

### **Inpatient psychiatric hospitalization and intensive psychiatric treatment programs**

**Inpatient psychiatric hospitalization.** We cover inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and Services of Plan Physicians and other Plan Providers who are licensed health care professionals acting within the scope of their license. We cover these Services at **no charge**.

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

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

### **Services not covered under this "Mental Health Services" section**

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

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

### **Ostomy and Urological Supplies**

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

### **About our soft goods formulary**

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

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

#### **Ostomy and urological supplies exclusion**

- Comfort, convenience, or luxury equipment or features

### **Outpatient Imaging, Laboratory, and Special Procedures**

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

- Diagnostic and therapeutic imaging, such as X-rays, mammograms, and ultrasound: **no charge** except that certain imaging procedures are covered at a **\$15 Copayment per procedure** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort
- MRI, CT, and PET: **no charge**
- Nuclear medicine: **no charge**
- Laboratory tests (including tests for specific genetic disorders for which genetic counseling is available):
  - ◆ laboratory tests to monitor the effectiveness of dialysis: **no charge**
  - ◆ fecal occult blood tests: **no charge**
  - ◆ cervical cancer screening—including screening for human papillomavirus (HPV), prostate specific antigen tests, cholesterol tests (lipid panel and profile), diabetes screening (fasting blood glucose tests), sexually transmitted disease (STD) tests, and HIV tests: **no charge**
  - ◆ all other laboratory tests: **no charge**
- Routine preventive retinal photography screenings: **no charge**
- All other diagnostic procedures provided by Plan Providers who are not physicians (such as EKGs and EEGs): **no charge** except that certain diagnostic procedures are covered at a **\$15 Copayment per procedure** if they are provided in an outpatient or

ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort

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

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

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

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

### **Outpatient Prescription Drugs, Supplies, and Supplements**

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

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

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## How to obtain covered items

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

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

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

## Outpatient drugs, supplies, and supplements

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

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

**Cost Sharing for outpatient drugs, supplies, and supplements.** The Cost Sharing for these items is a **\$10 Copayment** for up to a 100-day supply, except that the following items require payment of a different Cost Sharing:

- Drugs prescribed for the treatment of sexual dysfunction disorders: **50% Coinsurance** for up to a 100-day supply
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria) and elemental dietary enteral

formula when used as a primary therapy for regional enteritis: **no charge** for up to a 30-day supply

- Emergency contraceptive pills: **no charge**
- Hematopoietic agents for dialysis: **no charge** for up to a 30-day supply
- Continuity drugs (if this *Evidence of Coverage* is amended to exclude a drug that we have been covering and providing to you under this *Evidence of Coverage*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration): **50% Coinsurance** for up to a 30-day supply in a 30-day period

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

## Certain intravenous drugs, supplies, and supplements

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

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

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

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

## Day supply limit

The prescribing physician or dentist determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, Plan Physicians determine the amount of an item that constitutes a Medically Necessary 30- or 100-day supply for you. Upon payment of the Cost Sharing specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, you will receive the supply prescribed up to the day supply limit also specified in this section. The day supply limit is either a 30-day

supply in a 30-day period or a 100-day supply in a 100-day period. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantities that exceed the day supply limit. Note: We cover episodic drugs prescribed for the treatment of sexual dysfunction disorders up to a maximum of 8 doses in any 30-day period or 27 doses in any 100-day period.

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

### About our drug formulary

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

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

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

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

- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "Durable Medical Equipment for Home Use")

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

### Outpatient prescription drugs, supplies, and supplements exclusions

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

### Prosthetic and Orthotic Devices

We cover the devices specified in this "Prosthetic and Orthotic Devices" section if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is not ill or injured. Coverage is limited to the standard device that adequately meets your medical needs.

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

### Internally implanted devices

We cover at **no charge** internal devices implanted during covered surgery, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints.



### External devices

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

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres required to hold a prosthesis every 12 months
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect
- Other covered prosthetic and orthotic devices:
  - ◆ prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity
  - ◆ rigid and semi-rigid orthotic devices required to support or correct a defective body part

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

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

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

### Prosthetic and orthotic devices exclusions

- Dental appliances
- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Except as otherwise described above in this "Prosthetic and Orthotic Devices" section, nonrigid supplies, such as elastic stockings and wigs
- Comfort, convenience, or luxury equipment or features

- Shoes or arch supports, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications

### Reconstructive Surgery

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

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

You pay the following for covered reconstructive surgery Services:

- Office visits: **a \$15 Copayment per visit**
- Outpatient surgery: **a \$15 Copayment per procedure**
- Hospital inpatient care (including room and board, drugs, and Plan Physician Services): **no charge**

### Services not covered under this "Reconstructive Surgery" section

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

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

### Reconstructive surgery exclusions

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



## **Services Associated with Clinical Trials**

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

- You are diagnosed with cancer
- You are accepted into a phase I, II, III, or IV clinical trial for cancer
- Your treating Plan Physician, or your treating Non-Plan Physician if the Medical Group authorizes a written referral to the Non-Plan Physician for treatment of cancer (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section), recommends participation in the clinical trial after determining that it has a meaningful potential to benefit you
- The Services would be covered under this *Evidence of Coverage* if they were not provided in connection with a clinical trial
- The clinical trial has a therapeutic intent, and its end points are not defined exclusively to test toxicity
- The clinical trial involves a drug that is exempt under federal regulations from a new drug application, or the clinical trial is approved by: one of the National Institutes of Health, the federal Food and Drug Administration (in the form of an investigational new drug application), the U.S. Department of Defense, or the U.S. Department of Veterans Affairs

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

### **Services associated with clinical trials exclusions**

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

## **Skilled Nursing Facility Care**

Inside our Service Area, we cover at **no charge** up to 100 days per 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.

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

We cover the following Services:

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

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

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

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

## **Transplant Services**

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

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

- If either the Medical Group or the referral facility determines that you do not satisfy its respective



criteria for a transplant, we will only cover Services you receive before that determination is made

- Health Plan, Plan Hospitals, the Medical Group, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with our guidelines for Services for living transplant donors, we provide certain donation-related Services for a donor, or an individual identified by the Medical Group as a potential donor, whether or not the donor is a Member. These Services must be directly related to a covered transplant for you, which may include certain Services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Our guidelines for donor Services are available by calling our Member Service Call Center

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

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

### **Services not covered under this "Transplant Services" section**

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

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

### **Vision Services**

We cover the Services listed below at Plan Medical Offices or Plan Optical Sales Offices when prescribed by a Plan Physician or by a Plan Provider who is an optometrist.

#### **Optical Services**

**Eyeglasses and contact lenses.** We provide a **\$175 Allowance** toward the purchase price of any or all of the following every 24 months:

- Eyeglass lenses when a Plan Provider puts the lenses into a frame

- Eyeglass frames when a Plan Provider puts two lenses (at least one of which must have refractive value) into the frame
- Contact lenses, fitting, and dispensing

We will not provide the Allowance if we have provided an Allowance toward (or otherwise covered) lenses or frames within the previous 24 months.

The Allowance can only be used at the initial point of sale. If you do not use all of your Allowance at the initial point of sale, you cannot use it later.

If you have a change in prescription of at least .50 diopter in one or both eyes within 12 months of the initial point of sale, we will provide an Allowance toward the purchase price of a replacement eyeglass lens (or contact lens, fitting, and dispensing). The Allowance for these replacement lenses is **\$60** for single vision eyeglass lenses or contact lenses, fitting, and dispensing and **\$90** for multifocal eyeglass lenses.

**Special contact lenses.** We cover the following special contact lenses:

- Up to two Medically Necessary contact lenses, fitting, and dispensing per eye every 12 months (including lenses we covered under any other evidence of coverage offered by your Group) to treat aniridia (missing iris): **no charge**
- Up to six Medically Necessary aphakic contact lenses, fitting, and dispensing per eye per calendar year (including lenses we covered under any other evidence of coverage offered by your Group) to treat aphakia (absence of the crystalline lens of the eye) for Members through age 9: **no charge**
- If contact lenses will provide a significant improvement in your vision not obtainable with eyeglass lenses, we cover either one pair of contact lenses or an initial supply of disposable contact lenses every 24 months at **no charge**. When we cover these special contact lenses, you cannot use the Allowance mentioned under "Eyeglasses and contact lenses" for another 24 months. However, if the combination of special contact lenses and eyeglasses will provide a significant improvement in your vision not obtainable with special contact lenses alone, you can use that Allowance toward the purchase of the eyeglasses if we have not covered lenses or frames within the previous 24 months. If you have a change in prescription of at least .50 diopter in one or both eyes, we will cover special contact lens replacements, including fitting and dispensing for the eye(s) that have the .50 diopter change

### Services not covered under this "Vision Services" section

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

- Eye refraction exams to determine the need for vision correction and to provide a prescription for eyeglass lenses (refer to "Outpatient Care")
- Services related to the eye or vision other than those related to eyeglasses and contact lenses described in this section (refer to the applicable heading in this "Benefits and Cost Sharing" section)

### Vision Services exclusions

- Industrial frames
- Lenses and sunglasses without refractive value, except that this exclusion does not apply to any of the following:
  - ◆ a clear balance lens if only one eye needs correction
  - ◆ tinted lenses when Medically Necessary to treat macular degeneration or retinitis pigmentosa
- Replacement of lost, broken, or damaged lenses or frames
- Lens adornment, such as engraving, faceting, or jewelry
- Low-vision devices
- Non-prescription products, such as eyeglass holders, eyeglass cases, and repair kits

## Exclusions, Limitations, Coordination of Benefits, and Reductions

### Exclusions

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

### Certain exams and Services

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

Physician determines that the Services are Medically Necessary.

### Chiropractic Services

Chiropractic Services and the Services of a chiropractor.

### Conception by artificial means

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

### Cosmetic Services

Services that are intended primarily to change or maintain your appearance, except for Services covered under "Reconstructive Surgery" and the following prosthetic devices covered under "Prosthetic and Orthotic Devices" in the "Benefits and Cost Sharing" section: prostheses needed after a mastectomy and prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect.

### Custodial care

Custodial care means assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.

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

### Dental care

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

### Disposable supplies

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

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

### **Experimental or investigational Services**

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

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

This exclusion does not apply to any of the following:

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

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

### **Eye surgery**

- Services related to eye surgery or orthokeratologic Services for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism

### **Hair loss or growth treatment**

Services for the promotion, prevention, or other treatment of hair loss or hair growth.

### **Intermediate care**

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

### **Oral nutrition**

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

This exclusion does not apply to any of the following:

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

### **Residential care**

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

### **Routine foot care Services**

Routine foot care Services that are not Medically Necessary.

### **Services not approved by the federal Food and Drug Administration**

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

This exclusion does not apply to any of the following:

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

- Services covered under "Services Associated with Clinical Trials" in the "Benefits and Cost Sharing" section

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

### **Services related to a noncovered Service**

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

### **Speech therapy**

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

### **Surrogacy**

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

### **Transgender surgery**

#### **Travel and lodging expenses**

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

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

### **Limitations**

We will do our best to provide or arrange for our Members' health care needs in the event of unusual circumstances that delay or render impractical the provision of Services under this *Evidence of Coverage*, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor disputes. Under these extreme circumstances, if you have an Emergency Medical Condition, go to the nearest hospital as described under "Emergency Care" in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section, and we will provide coverage and reimbursement as described in that section.

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

### **Coordination of Benefits**

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

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

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

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



## **Reductions**

### **Employer responsibility**

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

### **Government agency responsibility**

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

### **Injuries or illnesses alleged to be caused by third parties**

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

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

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

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

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

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

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

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

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

### **Medicare benefits**

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

### **Surrogacy arrangements**

If you enter into a surrogacy arrangement, you must pay us Charges for covered Services you receive related to conception, pregnancy, or delivery in connection with

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

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

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

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

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

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

## U.S. Department of Veterans Affairs

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

## Workers' compensation or employer's liability benefits

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

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

## Dispute Resolution

### Grievances

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

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

- You are not satisfied with the quality of care you received
- You received a written denial of Services from the Medical Group or a "Notice of Non-Coverage" and you want us to cover the Services
- A Plan Physician has said that Services are not Medically Necessary and you want us to cover the Services
- You were told that Services are not covered and you believe that the Services should be covered
- You received care from a Non-Plan Provider that we did not authorize (other than Emergency Care, Post-

Stabilization Care, or Out-of-Area Urgent Care) and you want us to pay for the care

- We did not decide fully in your favor on a claim for Services described in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section and you want to appeal our decision
- You are dissatisfied with how long it took to get Services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility

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

- If we did not decide fully in your favor on a claim for Services described in the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section and you want to appeal our decision, you can submit your grievance in one of the following ways:
  - ◆ to the Claims Department at the following address:  
Kaiser Foundation Health Plan, Inc.  
Special Services Unit  
P.O. Box 23280  
Oakland, CA 94623
  - ◆ by calling our Member Service Call Center at 1-800-464-4000 or 1-800-390-3510 (TTY users call 1-800-777-1370)
- For all other issues, you can submit your grievance in one of the following ways:
  - ◆ to the Member Services Department at a Plan Facility (please refer to *Your Guidebook* for addresses)
  - ◆ by calling our Member Service Call Center at 1-800-464-4000 (TTY users call 1-800-777-1370)
  - ◆ through our Web site at **kp.org**

We will send you a confirmation letter within five days after we receive your grievance. We will send you our written decision within 30 days after we receive your grievance. If we do not approve your request, we will tell you the reasons and about additional dispute resolution options. Note: If we resolve your issue to your satisfaction by the end of the next business day after we receive your grievance orally, by fax, or through our Web site, and a Member Services representative notifies

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

### **Expedited grievance**

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

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

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

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

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

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



## Supporting Documents

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

## Who May File

The following persons may file a grievance:

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

## Department of Managed Health Care Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health

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

## Independent Medical Review (IMR)

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

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

- One of these situations applies to you:
  - ◆ you have a recommendation from a provider requesting Medically Necessary Services
  - ◆ you have received Emergency Care or Urgent Care from a provider who determined the Services to be Medically Necessary
  - ◆ you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition
- Your request for payment or Services has been denied, modified, or delayed based in whole or in part on a decision that the Services are not Medically Necessary
- You have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for expedited

grievances). The Department of Managed Health Care may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function

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

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

#### **Experimental or investigational denials**

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

- Your treating physician provided us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we cover than the therapy being requested. "Life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity
- If your treating physician is a Plan Physician, he or she recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying his or her recommendation
- You (or your Non-Plan Physician who is a licensed, and either a board-certified or board-eligible,

physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician's certification included a statement of the evidence relied upon by the physician in certifying his or her recommendation. We do not cover the Services of the Non-Plan Provider

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

### **Binding Arbitration**

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

#### **Scope of arbitration**

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

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *Evidence of Coverage* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. (Health Plan), including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, Services, irrespective of the legal theories upon which the claim is asserted
- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- The claim is *not* within the jurisdiction of the Small Claims Court
- If your Group must comply with the Employee Retirement Income Security Act (ERISA) requirements, the claim is *not* a benefit-related request that constitutes a "benefit claim" in Section 502(a)(1)(B) of ERISA. Note: Benefit claims under

this section of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor regulation prohibiting mandatory binding arbitration of this category of claim (29 CFR 2560.503-1(c)(4)) is modified, amended, repealed, superseded, or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without further notice

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

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

"Kaiser Permanente Parties" include:

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

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

### Initiating arbitration

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

transaction, or related circumstances in the Demand for Arbitration.

### Serving Demand for Arbitration

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

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

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

### Filing fee

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

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

### Number of arbitrators

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

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

If the Demand for Arbitration seeks total damages of more than \$200,000, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one jointly appointed by all Claimants and

one jointly appointed by all Respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

### **Payment of arbitrators' fees and expenses**

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

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

### **Costs**

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

### **Rules of Procedure**

Arbitrations shall be conducted according to the Rules of Procedure developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from our Member Service Call Center.

### **General provisions**

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

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

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

## **Termination of Membership**

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2010, your last minute of coverage was at 11:59 p.m. on December 31, 2009). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *Evidence of Coverage* after your membership terminates, except as provided under "Payments after Termination" in this "Termination of Membership" section.

### **Termination Due to Loss of Eligibility**

If you meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership will end at 11:59 p.m. on the last day of that month. For example, if you become ineligible on December 5, 2009, your termination date is January 1, 2010, and your last minute of coverage is at 11:59 p.m. on December 31, 2009.

### **Termination of Agreement**

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

## **Termination for Cause**

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

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

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

## **Termination for Nonpayment**

### **Nonpayment of Premiums**

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

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

if we receive full payment from your Group on or before your Group's next scheduled payment due date.

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

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

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

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

## **Termination of a Product or all Products**

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

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## **HIPAA Certificates of Creditable Coverage**

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

## **Payments after Termination**

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

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

## **State Review of Membership Termination**

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

## **Continuation of Membership**

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

## **Continuation of Group Coverage**

If at any time you become entitled to continuation of Group coverage such as Cal-COBRA, please examine

your coverage options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely. Note: Medical history does not impact premiums or eligibility for our Individual-Conversion Plan and HIPAA Individual Plan described under "Conversion from Group Membership to an Individual Plan" in this "Continuation of Membership" section. However, the individual plan premiums and coverage will be different from the premiums and coverage under your Group plan.

## **COBRA**

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

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

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

## **Cal-COBRA**

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

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

- Your effective date of COBRA coverage was on or after January 1, 2003

- You have exhausted the time limit for COBRA coverage and that time limit was 18 or 29 months
- You are not entitled to Medicare

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

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

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

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

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

**Changes to Cal-COBRA coverage and Premiums.** Your Cal-COBRA coverage is the same as for any similarly situated individual under your Group's *Agreement*, and your Cal-COBRA coverage and Premiums will change at the same time that coverage or Premiums change in your Group's *Agreement*. Your Group's coverage and Premiums will change on the renewal date of its *Agreement* (July 1), and may also change at other times if your Group's *Agreement* is amended. Your monthly invoice will reflect the current Premiums that are due for Cal-COBRA coverage, including any changes. For example, if your Group makes a change that affects Premiums retroactively, the amount we bill you will be adjusted to reflect the

retroactive adjustment in Premiums. Your Group can tell you whether this *Evidence of Coverage* is still in effect and give you a current one if this *Evidence of Coverage* has expired or been amended. You can also request one from our Member Service Call Center.

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

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

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



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

We will terminate your Family's memberships if we do not receive payment within 15 days of the date we mailed the Notice of Termination (notice of nonreceipt of payment). We will mail a notice confirming termination of membership, which will inform you of the following:

- That we have terminated the memberships of everyone in your Family for nonpayment of Premiums
- The date and time when the memberships of everyone in your Family ended
- Information explaining whether or not you can reinstate your memberships

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

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

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

- The date your membership is terminated for nonpayment of Premiums as described under "Termination for nonpayment of Cal-COBRA Premiums" in this "Continuation of Membership" section

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

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

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

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

#### **Coverage for a disabling condition**

If you became totally disabled after December 31, 1977, while you were a Member under your Group's



*Agreement* with us and while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates, coverage for your disabling condition will continue until any one of the following events occurs:

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

Your coverage will be subject to the terms of this *Evidence of Coverage*, including Cost Sharing.

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

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

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

### **Conversion from Group Membership to an Individual Plan**

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

#### **Kaiser Permanente Conversion Plan**

If you want to remain a Health Plan member, one option that may be available is an individual plan called "Kaiser Permanente Individual–Conversion Plan." You may be eligible to enroll in our Individual–Conversion Plan if you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section. Also, if you enroll in Group continuation coverage through COBRA, Cal-

COBRA, or USERRA, you may be eligible to enroll in our Individual–Conversion Plan when your Group continuation coverage ends. The premiums and coverage under our Individual–Conversion Plan are different from those under this *Evidence of Coverage*.

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

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

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

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

#### **HIPAA and other individual plans**

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



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

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

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

## Miscellaneous Provisions

### Administration of Agreement

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

### Advance directives

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

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

down your own views on life support and other treatments

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

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

### Agreement binding on Members

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

### Amendment of Agreement

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*. If this *Evidence of Coverage* is part of a health benefit plan that is subject to the Employee Retirement Income

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

### ERISA notices

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

#### **Newborns' and Mother's Health Protection Act.**

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

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

### Governing law

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

### Group and Members not our agents

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

### Health Insurance Counseling and Advocacy Program (HICAP)

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

### No waiver

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

### Nondiscrimination

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

### Notices

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

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

### Other formats for Members with disabilities

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

### Overpayment recovery

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

### Privacy practices

Kaiser Permanente will protect the privacy of your protected health information. We also require contracting providers to protect your protected health information.



Protected health information is health information that includes your name, Social Security number, or other information that reveals who you are. You may generally see and receive copies of your protected health information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your protected health information.

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

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

#### **Public policy participation**

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

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

#### **Telephone access (TTY)**

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



**Kaiser Foundation Health Plan, Inc.  
Northern California Region**

*A nonprofit corporation and a Medicare Advantage Organization*

## **Kaiser Permanente Senior Advantage (HMO) with Part D Evidence of Coverage for EL DORADO COUNTY**

Purchaser ID: 34936 Contract: 1 Version: 48 EOC Number: 1

*July 1, 2010, through June 30, 2011*

Member Service Call Center  
Seven days a week 8 a.m.–8 p.m.  
**1-800-443-0815** toll free  
**1-800-777-1370** (toll free TTY for the hearing/speech impaired)  
kp.org

This information may be available in a different format, including Spanish, Braille, large print, electronic text file, and audio tapes. Please call our Member Service Call Center if you need plan information in another format or language.

Es posible que se pueda obtener esta información en un formato diferente, incluido en español, braille, letra grande, archivo de texto electrónico y cintas de audio. Por favor llame a nuestro Centro de Llamadas para Servicios a los Miembros si necesita información sobre el Plan en otro formato o idioma.

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## Benefit Highlights

### Annual Out-of-Pocket Maximum for Certain Services

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

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

### Deductible or Lifetime Maximum

None

### Professional Services (Plan Provider office visits)

#### You Pay

Routine preventive care:

Physical exams .....	\$5 per visit
Family planning visits .....	\$5 per visit
Scheduled prenatal care visits and first postpartum visit .....	\$5 per visit
Eye exams for refraction and glaucoma screening .....	\$5 per visit
Hearing tests .....	\$5 per visit
Primary and specialty care visits .....	\$5 per visit
Urgent care visits.....	\$5 per visit
Physical, occupational, and speech therapy.....	\$5 per visit

### Outpatient Services

#### You Pay

Outpatient surgery and certain other outpatient procedures .....	\$5 per procedure
Allergy injection visits .....	\$3 per visit
Allergy testing visits.....	\$5 per visit
X-rays, annual mammograms, and lab tests .....	No charge
Manual manipulation of the spine .....	\$5 per visit
Health education:	
Individual visits .....	\$5 per visit
Group educational programs .....	No charge

### Hospitalization Services

#### You Pay

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

#### You Pay

Emergency Department visits .....	\$5 per visit
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Note: This Cost Sharing does not apply if admitted to the hospital as an inpatient within 24 hours for the same condition (see "Hospitalization Services" for inpatient Cost Sharing).

### Ambulance Services

#### You Pay

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

#### You Pay

Most covered outpatient items in accord with our drug formulary guidelines .....	\$10 for up to a 100-day supply
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### Durable Medical Equipment

#### You Pay

Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines .....	No charge
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### Mental Health Services

#### You Pay

Inpatient psychiatric hospitalization and intensive psychiatric treatment programs.....	No charge
Outpatient individual and group visits .....	\$5 per individual visit \$2 per group visit

### Chemical Dependency Services

#### You Pay

Inpatient detoxification.....	No charge
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<b>Chemical Dependency Services</b>	<b>You Pay</b>
Outpatient individual visits .....	\$5 per visit
Outpatient group visits .....	\$2 per visit
<b>Home Health Services</b>	<b>You Pay</b>
Home health care (part-time, intermittent) .....	No charge
<b>Other</b>	<b>You Pay</b>
Eyewear purchased from Plan Optical Sales Offices every 24 months.....	Amount in excess of \$175 Allowance
Hearing aid(s) every 36 months .....	Amount in excess of \$2,500 Allowance per aid
Skilled Nursing Facility care (up to 100 days per benefit period).....	No charge
Prosthetic and orthotic devices or ostomy and urological supplies .....	No charge
Hospice care for Members without Medicare Part A .....	No charge

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

## Introduction

Kaiser Foundation Health Plan, Inc. (Health Plan) has a contract with the Centers for Medicare & Medicaid Services as a Medicare Advantage Organization. This Medicare contract is renewed annually.

This contract provides Medicare Services (including Medicare Part D prescription drug coverage) through "Kaiser Permanente Senior Advantage with Part D" (Senior Advantage), except for hospice care for Members with Medicare Part A and qualifying clinical trials, which are covered under Original Medicare. Senior Advantage is for Members entitled to Medicare, providing the advantages of combined Medicare and Health Plan benefits. Enrollment in this Senior Advantage plan means that you are automatically enrolled in Medicare Part D.

This *Evidence of Coverage* describes our Senior Advantage health care coverage provided under the *Group Agreement (Agreement)* between Health Plan (Kaiser Foundation Health Plan, Inc.) and your Group (the entity with which Health Plan has entered into the *Agreement*). For benefits provided under any other Health Plan program, refer to that plan's evidence of coverage.

**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.

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.

## Term of this Evidence of Coverage

This *Evidence of Coverage* is for the period July 1, 2010, through June 30, 2011, unless amended. Your Group can tell you whether this *Evidence of Coverage* is still in effect and give you a current one if this *Evidence of Coverage* has been amended.

## About Kaiser Permanente

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

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

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Cost Sharing" section
- Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency, Post-Stabilization, and Urgent Care from Non-Plan Providers" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Cost Sharing" section
- Prescription drugs from Non-Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section
- Visiting member care as described under "Visiting Other Regions" in the "How to Obtain Services" section

## Definitions

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

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

**Catastrophic Coverage Stage:** The stage in the Part D Drug Benefit where you pay a low Copayment or Coinsurance for your Part D drugs after you or other qualified parties on your behalf have spent \$4,550 in covered Part D drugs during the covered year.

**Centers for Medicare & Medicaid Services:** The federal agency that administers the Medicare program.

**Charges:** Charges means the following:

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

**Clinically Stable:** You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

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

**Comprehensive Outpatient Rehabilitation Facility (CORF):** A facility that mainly provides rehabilitation Services after an illness or injury, and provides a variety of Services, including physician's Services, physical therapy, social or psychological Services, and outpatient rehabilitation.

**Copayment:** A specific dollar amount that you must pay when you receive a covered Service as described in the

"Benefits and Cost Sharing" section. Note: The dollar amount of the Copayment can be \$0 (no charge).

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

**Coverage Determination:** An initial determination we make about whether a Part D drug prescribed for you is covered under Part D and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription for a Part D drug to a Plan Pharmacy and the pharmacy tells you the prescription isn't covered by us, that isn't a coverage determination. You need to call or write us to ask for a formal decision about the coverage if you disagree.

**Dependent:** A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

**Emergency Care:**

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

**Emergency Medical Condition:** Any of the following:

- A medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs
- Active labor when there isn't enough time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety

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

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

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

**Health Plan:** Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. This *Evidence of*

*Coverage* sometimes refers to Health Plan as "we" or "us."

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

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

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

**Medicare:** The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). In this *Evidence of Coverage*, Members who are "eligible for" Medicare Part A or B are those who would qualify for Medicare Part A or B coverage if they applied for it. Members who are "entitled to" or "have" Medicare Part A or B are those who have been granted Medicare Part A or B coverage. Also, a person enrolled in a Medicare Part D plan has Medicare Part D by virtue of his or her enrollment in the Part D plan (this *Evidence of Coverage* is for a Part D plan).

**Medicare Advantage Organization:** A public or private entity organized and licensed by a state as a risk-bearing entity that has a contract with the Centers for Medicare & Medicaid Services to provide Services covered by Medicare, except for hospice care and clinical trials covered by Original Medicare. Kaiser Foundation Health Plan, Inc., is a Medicare Advantage Organization.

**Medicare Advantage Plan:** Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. Medicare Advantage Plans may also offer Medicare Part D (prescription drug coverage). This *Evidence of Coverage* is for a Medicare Part D plan.

**Medigap (Medicare Supplement Insurance) Policy:** Medicare supplement insurance sold by private insurance companies to fill "gaps" in the Original Medicare plan coverage. Medigap policies only work with the Original Medicare plan. (A Medicare Advantage Plan is not a Medigap policy.)

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

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

**Non-Plan Pharmacy:** A pharmacy other than a Plan Pharmacy. These pharmacies are also called "out-of-network pharmacies."

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

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

**Non-Plan Skilled Nursing Facility:** A Skilled Nursing Facility other than a Plan Skilled Nursing Facility.

**Organization Determination:** An initial determination we make about whether we will cover or pay for Services that you believe you should receive.

**Original Medicare ("Traditional Medicare" or "Fee-for-Service Medicare"):** The Original Medicare plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay a deductible. Medicare pays its share of the Medicare approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance), and is available everywhere in the United States and its territories.

**Out-of-Area Urgent Care:** Medically Necessary Services to prevent serious deterioration of your health resulting from an unforeseen illness or an unforeseen injury if all of the following are true:

- You are temporarily outside our Service Area
- You reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our Service Area

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

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

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



Medical Offices, please call our Member Service Call Center.

**Plan 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 Call Center.

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

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

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

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

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

**Premiums:** The periodic amounts that your Group is responsible for paying for your membership under this *Evidence of Coverage*.

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

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

**Service Area:** The geographic area approved by the Centers for Medicare & Medicaid Services within which an eligible person may enroll in Senior Advantage. Note: Subject to approval by the Centers for Medicare & Medicaid Services, we may reduce our Service Area effective any January 1 by giving prior written notice to your Group. We may expand our Service Area at any time by giving written notice to your Group. ZIP codes are subject to change by the U.S. Postal Service.

The following counties are entirely inside our Service Area: Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, San Mateo, Solano, and Stanislaus.

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

- Amador: 95640, 95669
- El Dorado: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762
- Fresno: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–30, 93741, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–79, 93784, 93786, 93790–94, 93844, 93888
- Kings: 93230, 93232, 93242, 93631, 93656
- Madera: 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720
- Mariposa: 93601, 93623, 93653
- Napa: 94503, 94508, 94515, 94558–59, 94562, 94567, 94573–74, 94576, 94581, 94589–90, 94599, 95476
- Placer: 95602–04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95692, 95703, 95722, 95736, 95746–47, 95765
- Santa Clara: 94022–24, 94035, 94039–43, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–36, 95138–41, 95148, 95150–61, 95164, 95170, 95172–73, 95190–94, 95196
- Sonoma: 94515, 94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, 95492
- Sutter: 95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 95836–37

- Tulare: 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
- Yolo: 95605, 95607, 95612, 95616–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99
- Yuba: 95692, 95903, 95961

For each ZIP code listed for a county, our Service Area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside our Service Area, unless either (1) that other county is entirely in our Service Area as listed above, or (2) that other county is also listed above and that ZIP code is also listed for that other county. Also, the ZIP codes listed above may include ZIP codes for Post Office boxes and commercial rental mailboxes. A Post Office box or rental mailbox cannot be used to determine whether you meet the residence eligibility requirements for Senior Advantage. Your permanent residence address must be used to determine your Senior Advantage eligibility.

**Services:** Health care services or items.

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

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

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

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

## Premiums, Eligibility, and Enrollment

### Premiums

Your Group is responsible for paying Premiums. If you are responsible for any contribution to the Premiums, your Group will tell you the amount and how to pay your Group. In addition to any amount you must pay your Group, you must also continue to pay Medicare your monthly Medicare premium.

If you do not have Medicare Part A, you may be eligible to purchase Medicare Part A from Social Security. Please contact the Social Security Administration for more information. If you become entitled to Medicare Part A, this may reduce the amount you would be expected to pay to your Group, please check with your Group's benefits administrator.

**Medicare Part D late enrollment penalty.** You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage, or you experienced a continuous period of 63 days or more when you didn't have creditable prescription drug coverage. The amount of the penalty depends on how long you waited before you enrolled in drug coverage after you became eligible or how many months after 63 days you went without drug coverage (this *Evidence of Coverage* is for a Part D plan). Your Group will inform you if the penalty applies to you. However, if you qualify for extra help, you may not have to pay a penalty. If you disagree with your late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Call our Member Service Call Center at the number on the front of this booklet to find out more about how to do this.

### Extra help with drug plan expenses

Medicare provides "extra help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you may get help paying for any Medicare drug plan's monthly premium, and prescription Copayments. If you qualify, this extra help will count toward your out-of-pocket costs.

People with limited income and resources may qualify for extra help one of two ways. The amount of extra help you get will depend on your income and resources.

- **You automatically qualify for extra help and don't need to apply.** If you have full coverage from a state Medicaid program, get help from Medicaid paying



your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare notifies people who automatically qualify for extra help

- **You apply and qualify for extra help.** If you think you may qualify, call Social Security toll free at 1-800-772-1213 (TTY users call 1-800-325-0778) or visit [www.socialsecurity.gov](http://www.socialsecurity.gov) on the Web. You may also be able to apply at your State Medical Assistance (Medicaid) office. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next

If you qualify for extra help, we will send you an *Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs* that explains your costs as a member of our Plan. If the amount of your extra help changes during the year, we will also mail you an updated *Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs*.

#### **What if you believe you have qualified for extra help**

If you believe you have qualified for extra help and you believe that you are paying an incorrect Cost Sharing amount when you get your prescription at a Plan Pharmacy, we have established a process that will allow you to either request assistance in obtaining evidence of your proper Cost Sharing level, or, if you already have the evidence, to provide this evidence to us. If you aren't sure what evidence to provide us, please contact our Member Service Call Center. The evidence is often a letter from either your state Medicaid or Social Security office that states you are qualified for extra help. You or your appointed representative may need to provide the evidence to a Plan Pharmacy when obtaining covered Part D prescriptions so that we can charge you the appropriate Cost Sharing amount until the Centers for Medicare & Medicaid Services updates its records to reflect your current status. Once the Centers for Medicare & Medicaid Services updates its records, you will no longer need to present the evidence to a Plan Pharmacy. In order for the Centers for Medicare & Medicaid Services to update its records, you must send your evidence to one of the following locations and we will forward your evidence to the Centers for Medicare & Medicaid Services for updating:

- Kaiser Foundation Health Plan, Inc.  
California Service Center  
Attn: Best Available Evidence  
P.O. Box 232407  
San Diego, CA 92193-2407
- Fax it toll free to 1-866-311-0514

- Bring it to a Plan Pharmacy or Member Services office at a Plan Facility listed in *Your Guidebook to Kaiser Permanente Services*

Note: If you do not have documentation, you can request that our Plan Pharmacy assist you or you may call our Member Service Call Center to assist you.

When we receive the evidence showing your Cost Sharing level, we will update our system so that you can pay the correct Cost Sharing when you get your next prescription at our Plan Pharmacy. If you overpay your Cost Sharing, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future Cost Sharing. If our Plan Pharmacy hasn't collected Cost Sharing from you and is carrying your Cost Sharing as a debt owed by you, we may make the payment directly to our Plan Pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact our Member Service Call Center if you have questions.

#### **Who Is Eligible**

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

#### **Group eligibility requirements**

You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of its eligibility requirements, such as Dependent eligibility requirements. Please note that your Group might not allow enrollment to some persons who meet the requirements described under "Additional eligibility requirements" below.

#### **Senior Advantage eligibility requirements**

- You must be entitled to benefits under Medicare Part B
- Your Medicare coverage must be primary and your Group's health care plan must be secondary
- You may not be enrolled in another Medicare health plan or Medicare Prescription Drug Plan
- You may enroll in Senior Advantage regardless of health status, except that you may not enroll if you have end-stage renal disease. This restriction does not apply to you if you are currently a Health Plan Northern California or Southern California Region member and you developed end-stage renal disease while a member
- You may not be able to enroll if Senior Advantage has reached a capacity limit that the Centers for

Medicare & Medicaid Services has approved. This limitation does not apply if you are currently a Health Plan Northern California or Southern California Region member who is eligible for Medicare (for example, when you turn age 65)

### Service Area eligibility requirements

You must live in our Service Area, unless you have been continuously enrolled in Senior Advantage since December 31, 1998, and lived outside our Service Area during that entire time. In which case, you may continue your membership unless you move and are still outside our Service Area. The "Definitions" section describes our Service Area and how it may change.

**Moving outside our Service Area.** If you permanently move outside our Service Area, or you are temporarily absent from our Service Area for a period of more than six months in a row, you must notify us and you cannot continue your Senior Advantage membership under this *Evidence of Coverage*. Send your notice to Kaiser Foundation Health Plan, Inc., California Service Center, P.O. Box 232400, San Diego, CA 92193. It is in your best interest to notify us as soon as possible because until your Senior Advantage coverage is officially terminated by the Centers for Medicare & Medicaid Services, you will not be covered by us or Original Medicare for any care you receive from Non-Plan Providers, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Cost Sharing" section
- Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency, Post-Stabilization, and Urgent Care from Non-Plan Providers" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Cost Sharing" section
- Prescription drugs from Non-Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section
- Visiting member care as described under "Visiting Other Regions" in the "How to Obtain Services" section

If you move to another Region's service area, please contact your Group to learn about your Group health care options. You may be able to enroll in the new service area if there is an agreement between your Group and

that Region, but the plan, including coverage, premiums, and eligibility requirements might not be the same. Please call our Member Service Call Center for more information about our other Regions, including their locations in the District of Columbia and parts of Southern California, Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington.

### Additional eligibility requirements

You may be eligible to enroll as a Subscriber if you are one of the following persons:

- An employee of your Group
- A proprietor or partner of your Group
- Otherwise entitled to coverage under a trust agreement, retirement benefit program, or employment contract (unless the Internal Revenue Service considers you self-employed)

If you are a Subscriber enrolled under this *Evidence of Coverage* or a subscriber enrolled in a non-Medicare plan offered by your Group, the following persons may be eligible to enroll as your Dependents under this *Evidence of Coverage* if they meet all the other requirements described under "Group eligibility requirements," "Senior Advantage eligibility requirements," and "Service Area eligibility requirements" in this "Who Is Eligible" section:

- Your Spouse. For the purposes of this *Evidence of Coverage*, the term "Spouse" includes your registered domestic partner who meets all the requirements of Section 297 of the California Family Code, or your domestic partner in accord with your Group's requirements, if any
- Your or your Spouse's unmarried children (including adopted children or children placed with you for adoption) who are under age 19, or under age 23 if a student as defined by your Group
- Other unmarried dependent persons (but not including foster children) who meet all of the following requirements:
  - ♦ they are under age 19, or under age 23 if a student as defined by your Group
  - ♦ they receive all of their support and maintenance from you or your Spouse
  - ♦ they permanently reside with the Subscriber
  - ♦ you or your Spouse is the court-appointed guardian (or was when the person reached age 18) or the person's parent is an enrolled Dependent under your family coverage
- Dependents who meet the Dependent eligibility requirements, except for the age limit, may be eligible



as a disabled dependent if they meet all the following requirements:

- ◆ they are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred prior to reaching the age limit for Dependents
- ◆ they receive 50 percent or more of their support and maintenance from you or your Spouse
- ◆ you give us proof of their incapacity and dependency within 60 days after we request it (see "Disabled dependent certification" below in this "Additional eligibility requirements" section)

Note: If you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this *Evidence of Coverage*, you may be able to enroll them as your dependents under a non-Medicare plan offered by your Group. Please contact your Group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

**Disabled dependent certification.** A dependent who meets the Dependent eligibility requirements except for the age limit may be eligible as a disabled dependent as described above under "Additional eligibility requirements" in this "Premiums, Eligibility, and Enrollment" section. You must provide us documentation of your dependent's incapacity and dependency as follows:

- If your Dependent is a Member, we will send you a notice of his or her membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. Your Dependent's membership will terminate as described in our notice unless you provide us documentation of his or her incapacity and dependency within 60 days of receipt of our notice and we determine that he or she is eligible as a disabled dependent. If you provide us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that your Dependent does not meet the eligibility requirements as a disabled dependent, we will notify you that he or she is not eligible and let you know the membership termination date. If we determine that your Dependent is eligible as a disabled dependent, there will be no lapse in coverage. Also, two years after the date that your Dependent reached the age limit, you must provide us documentation of his or her incapacity and dependency annually within 60 days after we request it so that we can determine if he or she continues to be eligible as a disabled dependent

- If your dependent is not a Member and you are requesting enrollment, you must provide us documentation of his or her incapacity and dependency within 60 days after we request it so that we can determine if he or she is eligible to enroll as a disabled dependent. If we determine that your dependent is eligible as a disabled dependent, you must provide us documentation of his or her incapacity and dependency annually within 60 days after we request it so that we can determine if he or she continues to be eligible as a disabled dependent

**Student eligibility.** In order for a Dependent age 19 and over to be eligible for membership as a student, as described above under "Additional eligibility requirements" in this "Who Is Eligible" section, one of the following must occur:

- If your Group has an agreement with us for the Group to certify student eligibility, then the Subscriber must follow the Group's procedures for certifying student eligibility and the Group must then certify the student's eligibility (your Group can tell you whether it has an agreement with us to certify student eligibility and, if it does, what its procedures are)
- If your Group does not have an agreement with us to certify student eligibility, then the Subscriber must complete and send us our student certification form affirming that the Dependent is a student as defined by your Group. You can get a copy of the form by visiting our Web site at [kp.org](http://kp.org) or by calling our Member Service Call Center

Breaks in the school calendar will not disqualify a Dependent from being classified as a student for eligibility purposes. Students taking a medically necessary leave of absence are classified as students for eligibility purposes for up to 12 months, though they will remain eligible for membership only if they continue to meet all other eligibility requirements. Dependent Members age 19 and over who are eligible for membership because they are students and who take a medically necessary leave of absence will remain covered until the earliest of the following dates:

- The date the leave ends
- The date that is 12 months after the leave began
- The date that coverage ends for a reason other than the Member's student status (for example, if the student reaches age 23)

Students who return to school after their leave ends may be eligible for membership if they meet all eligibility requirements. Documentation of the medical necessity for the leave must be submitted at least 30 days before the leave begins, if the absence and the medical reason

for the absence are foreseeable. If the absence and the medical reason for the absence are not foreseeable, then documentation of the medical necessity for the leave must be submitted within 30 days after the leave begins.

## **When You Can Enroll and When Coverage Begins**

Your Group is required to inform you when you are eligible to enroll and what your effective date of coverage is under this *Evidence of Coverage*. If you are eligible to enroll as described under "Who Is Eligible" in this "Premiums, Eligibility, and Enrollment" section, then as described in this "When You Can Enroll and When Coverage Begins" section, enrollment is permitted and membership begins at the beginning (12:00 a.m.) of the effective date of coverage, except that:

- Your Group may have additional requirements that we have approved, which allow enrollment in other situations
- The effective date of your Senior Advantage coverage under this *Evidence of Coverage* must be confirmed by the Centers for Medicare & Medicaid Services, as described under "Effective date of Senior Advantage coverage" in this "When You Can Enroll and When Coverage Begins" section

If you are a Subscriber under this *Evidence of Coverage* and you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this *Evidence of Coverage*, you may be able to enroll them as your dependents under a non-Medicare plan offered by your Group. Please contact your Group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

If you are eligible to be a Dependent under this *Evidence of Coverage* but the subscriber in your family is enrolled under a non-Medicare plan offered by your Group, the subscriber must follow the rules applicable to Subscribers who are enrolling Dependents in this "When You Can Enroll and When Coverage Begins" section.

### **Effective date of Senior Advantage coverage**

After we receive your completed Senior Advantage Election Form, we will submit your enrollment request to the Centers for Medicare & Medicaid Services for confirmation and send you a notice indicating the proposed effective date of your Senior Advantage coverage under this *Evidence of Coverage*.

If the Centers for Medicare & Medicaid Services confirms your Senior Advantage enrollment and effective date, we will send you a notice that confirms

your enrollment and effective date. If the Centers for Medicare & Medicaid Services tells us that you do not have Medicare Part B coverage, we will notify you that you will be disenrolled from Senior Advantage.

### **New employees**

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person, to your Group within 31 days.

**Effective date of Senior Advantage coverage.** The effective date of Senior Advantage coverage for new employees and their eligible family Dependents is determined by your Group, subject to confirmation by the Centers for Medicare & Medicaid Services.

### **Adding new Dependents to an existing account**

To enroll a Dependent who first becomes eligible to enroll after you became a Subscriber (such as a new Spouse, a newborn child, or a newly adopted child), you must submit a Health Plan–approved change of enrollment form and a Senior Advantage Election Form to your Group within 31 days after the Dependent first becomes eligible.

**Effective date of Senior Advantage coverage.** The effective date of coverage for newly acquired Dependents is determined by your Group, subject to confirmation by the Centers for Medicare & Medicaid Services.

### **Group open enrollment**

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person to your Group during your Group's open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the effective date of coverage, which is subject to confirmation by the Centers for Medicare & Medicaid Services.

### **Special enrollment**

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

- You become eligible as described in this "Special enrollment" section
- You did not enroll when you were first eligible and your Group does not give us a written statement that



verifies you signed a document that explained restrictions about enrolling in the future. Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, from the Subscriber

**Special enrollment due to new Dependents.** You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, within 30 days after marriage, establishment of domestic partnership, birth, adoption, or placement for adoption by submitting to your Group a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person.

Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from marriage is no later than the first day of the month following the date your Group receives an enrollment application, and a Senior Advantage Election Form for each person, from the Subscriber. Subject to confirmation by the Centers for Medicare & Medicaid Services, enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, adoption, or placement for adoption.

**Special enrollment due to loss of other coverage.** You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, if all of the following are true:

- The Subscriber or at least one of the Dependents had other coverage when he or she previously declined Health Plan coverage
- The loss of the other coverage is due to one of the following:
  - ◆ exhaustion of COBRA coverage
  - ◆ termination of employer contributions for non-COBRA coverage
  - ◆ loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due legal separation or divorce, reaching the age limit for dependent children, or the subscriber's death, termination of employment, or reduction in hours of employment
  - ◆ loss of eligibility (but not termination for cause) for Medicaid coverage (known as Medi-Cal in California), Children's Health Insurance Program coverage (known as the Healthy Families Program

in California), or Access for Infants and Mothers Program coverage

- ◆ reaching a lifetime maximum on all benefits

Note: If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, only one of you must meet the requirements stated above.

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, to your Group within 30 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for Medicaid, Children's Health Insurance Program, or Access for Infants and Mothers Program coverage. Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application, and Senior Advantage Election Form for each person, from the Subscriber.

**Special enrollment due to court or administrative order.** Within 31 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person.

Subject to confirmation by the Centers for Medicare & Medicaid Services, your Group will determine the effective date of an enrollment resulting from a court or administrative order, except that subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date cannot be earlier than the date of the order and cannot be later than the first day of the month following the date of the order.

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

## How to Obtain Services

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

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Cost Sharing" section
- Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency, Post-Stabilization, and Urgent Care from Non-Plan Providers" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Cost Sharing" section
- Prescription drugs from Non-Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section
- Visiting member care as described under "Visiting Other Regions" in this "How to Obtain Services" section

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

### Routine Care

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

### Urgent Care

When you are sick or injured, you may have an Urgent Care need. An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice nurse telephone number at a Plan Facility. Please refer to *Your*

*Guidebook* for advice nurse and Plan Facility telephone numbers.

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

### Our Advice Nurses

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. Whether you are calling for advice or to make an appointment, you can speak to an advice nurse. They can often answer questions about a minor concern, tell you what to do if a Plan Medical Office is closed, or advise you about what to do next, including making a same-day Urgent Care appointment for you if it's medically appropriate. To reach an advice nurse, please refer to *Your Guidebook* for the telephone numbers.

### Your Personal Plan Physician

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

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

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

## Getting a Referral

### Referrals to Plan Providers

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

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

### Medical Group authorization procedure for certain referrals

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

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

Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our soft goods formulary, please refer to "Ostomy and Urological Supplies" in the "Benefits and Cost Sharing" section

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

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

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

needed, and the date that the Medical Group expects to make a decision.

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

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

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

## Second Opinions

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

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

- A diagnosis is in doubt due to conflicting test results
- The Plan Physician is unable to diagnose the condition
- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have concerns about the diagnosis or plan of care

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

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

## Contracts with Plan Providers

### **How Plan Providers are paid**

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

### **Financial liability**

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

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

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements.

**Completion of Services.** If you are undergoing treatment for specific conditions from a Plan Physician (or certain other providers) when the contract with him or her ends (for reasons other than medical disciplinary cause, criminal activity, or the provider's voluntary



termination), you may be eligible to continue receiving covered care from the terminated provider for your condition. The conditions that are subject to this continuation of care provision are:

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

The Services must be otherwise covered under this *Evidence of Coverage*. Also, the terminated provider must agree in writing to our contractual terms and conditions and comply with them for Services to be covered by us. The Cost Sharing for the Services of a terminated provider is the Cost Sharing required for Services provided by a Plan Provider as described in the "Benefits and Cost Sharing" section.

For more information about this provision, or to request the Services, please call our Member Service Call Center.

### **Visiting Other Regions**

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

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

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

### **Your ID Card**

Each Member's Kaiser Permanente ID card has a medical record number on it, which you will need when you call for advice, make an appointment, or go to a provider for

covered care. When you get care, please bring your Kaiser Permanente ID card and a photo ID. Your medical record number is used to identify your medical records and membership information. Your medical record number should never change. Please call our Member Service Call Center if we ever inadvertently issue you more than one medical record number or if you need to replace your Kaiser Permanente ID card.

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

### **Your Medicare card**

As a Member, you will not need your red, white, and blue Medicare card to get covered Services, but do keep it in a safe place in case you need it later.

### **Getting Assistance**

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

### **Member Services**

Most Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Call Center representatives are available to assist you seven days a week from 8 a.m. to 8 p.m. toll free at 1-800-443-0815 or 1-800-777-1370 (TTY for the deaf, hard of hearing, or speech impaired). For your convenience, you can also contact us through our Web site at [kp.org](http://kp.org).

Member Services representatives at our Plan Facilities and Member Service Call Center can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace your ID card. These representatives can also help you if you need to file a

claim as described in the "Requests for Payment" section.

### Interpreter services

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

## Plan Facilities

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

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

### Plan Hospitals and Plan Medical Offices

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

#### Alameda

- Medical Offices: 2417 Central Ave.

#### Antioch

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

#### Campbell

- Medical Offices: 220 E. Hacienda Ave.

#### Clovis

- Medical Offices: 2071 Herndon Ave.

#### Daly City

- Medical Offices: 395 Hickey Blvd.

#### Davis

- Medical Offices: 1955 Cowell Blvd.

#### Elk Grove

- Medical Offices: 9201 Big Horn Blvd.

#### Fairfield

- Medical Offices: 1550 Gateway Blvd.

#### Folsom

- Medical Offices: 2155 Iron Point Rd.

#### Fremont

- Hospital and Medical Offices: 39400 Paseo Padre Pkwy.

#### Fresno

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

#### Gilroy

- Medical Offices: 7520 Arroyo Circle

#### Hayward

- Hospital and Medical Offices: 27400 Hesperian Blvd.

#### Lincoln

- Medical Offices: 1900 Dresden Dr.

#### Livermore

- Medical Offices: 3000 Las Positas Rd.

#### Manteca

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

#### Martinez

- Medical Offices: 200 Muir Rd.

#### Milpitas

- Medical Offices: 770 E. Calaveras Blvd.



**Modesto**

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

**Mountain View**

- Medical Offices: 555 Castro St.

**Napa**

- Medical Offices: 3285 Claremont Way

**Novato**

- Medical Offices: 97 San Marin Dr.

**Oakhurst**

- Medical Offices: 40595 Westlake Dr.

**Oakland**

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

**Petaluma**

- Medical Offices: 3900 Lakeville Hwy.

**Pinole**

- Medical Offices: 1301 Pinole Valley Rd.

**Pleasanton**

- Medical Offices: 7601 Stoneridge Dr.

**Rancho Cordova**

- Medical Offices: 10725 International Dr.

**Redwood City**

- Hospital and Medical Offices: 1150 Veterans Blvd.

**Richmond**

- Hospital and Medical Offices: 901 Nevin Ave.

**Rohnert Park**

- Medical Offices: 5900 State Farm Dr.

**Roseville**

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

**Sacramento**

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

**San Bruno**

- Medical Offices: 901 El Camino Real

**San Francisco**

- Hospital and Medical Offices: 2425 Geary Blvd.

**San Jose**

- Hospital and Medical Offices: 250 Hospital Pkwy.

**San Rafael**

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

**Santa Clara**

- Hospital and Medical Offices: 700 Lawrence Expwy.

**Santa Rosa**

- Hospital and Medical Offices: 401 Bicentennial Way

**Selma**

- Medical Offices: 2651 Highland Ave.

**South San Francisco**

- Hospital and Medical Offices: 1200 El Camino Real

**Stockton**

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

**Tracy**

- Medical Offices: 2185 W. Grant Line Rd.

**Turlock**

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

**Union City**

- Medical Offices: 3553 Whipple Rd.

**Vacaville**

- Hospital and Medical Offices: 1 Quality Dr.

**Vallejo**

- Hospital and Medical Offices: 975 Sereno Dr.

**Walnut Creek**

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

***Your Guidebook to Kaiser Permanente Services (Your Guidebook)***

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

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

## **Provider Directory**

We will send you annually either a provider directory or an update to your provider directory that lists our Plan Providers. If you don't have the provider directory, you can request a copy from our Member Service Call Center. Also, a complete list of Plan Providers in your area is available on our Web site at [kp.org](http://kp.org).

## **Pharmacy Directory**

The *Kaiser Permanente Medicare Part D Pharmacy Directory* lists the locations of Plan Pharmacies, which are also called "network pharmacies." The pharmacy directory provides additional information about obtaining prescription drugs. It is subject to change and periodically updated. We mail it annually and you can get a copy by calling our Member Service Call Center or by visiting our Web site at [kp.org/seniormedrx](http://kp.org/seniormedrx).

## **Emergency, Post-Stabilization, and Urgent Care from Non-Plan Providers**

This "Emergency, Post-Stabilization, and Urgent Care from Non-Plan Providers" section explains how to obtain covered Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care from Non-Plan Providers. We do not cover the Non-Plan Provider care discussed in this section unless it meets both of the following requirements:

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

## **Prior Authorization**

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

## **Emergency Care**

If you have an Emergency Medical Condition, call 911 or go to the nearest hospital (including an emergency room or urgent care center). When you have an Emergency Medical Condition, we cover Emergency Care anywhere in the world.

An Emergency Medical Condition is any of the following:

- A medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs
- Active labor when there isn't enough time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety

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

## **Post-Stabilization Care**

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

We cover Post-Stabilization Care if one of the following is true:

- We provide or authorize the care
- The care was Medically Necessary to maintain stabilization and it was administered within one hour following a request for authorization and we have not yet responded